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ABSTRACT

This study examines cultural diversity of the population served by vocational rehabilitation and emphasizes the importance of building capacity within organizations and service personnel to effectively serve diverse populations. Chapter 1 provides an introduction to the study noting its purpose and scope and intended audience. Chapter 2 reviews the major barriers to improving services and the quality of life for people with disabilities. Barriers are described at the societal, professional, organizational, and service provider levels. Chapter 3 is an overview of the historical and philosophical background of cultural diversity in rehabilitation. This historical review shows that the prevailing strategy of "compensatory education and training" and promotion of "tolerance" has achieved only modest outcomes. Chapter 4 focuses upon a model for developing a culturally responsive rehabilitation organization. A human resource development and management framework is applied to various elements of rehabilitation organizations. Chapter 5 focuses on methods and strategies for delivering rehabilitation services and reviews important skills, attributes, and approaches. Chapter 6 provides recommendations for achieving culturally responsive organizations and developing culturally competent rehabilitation practitioners. Chapter 7 provides a compendium of international and technical assistance resources. Appendices include a glossary, case studies, and a listing of study group members. Contains 126 references. (DB)

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ED 376 648

Cultural Diversity in Rehabilitation

Nineteenth Institute on Rehabilitation Issues

Arkansas Research & Training Center in Vocational Rehabilitation   University of Arkansas at Fayetteville   Arkansas Rehabilitation Services

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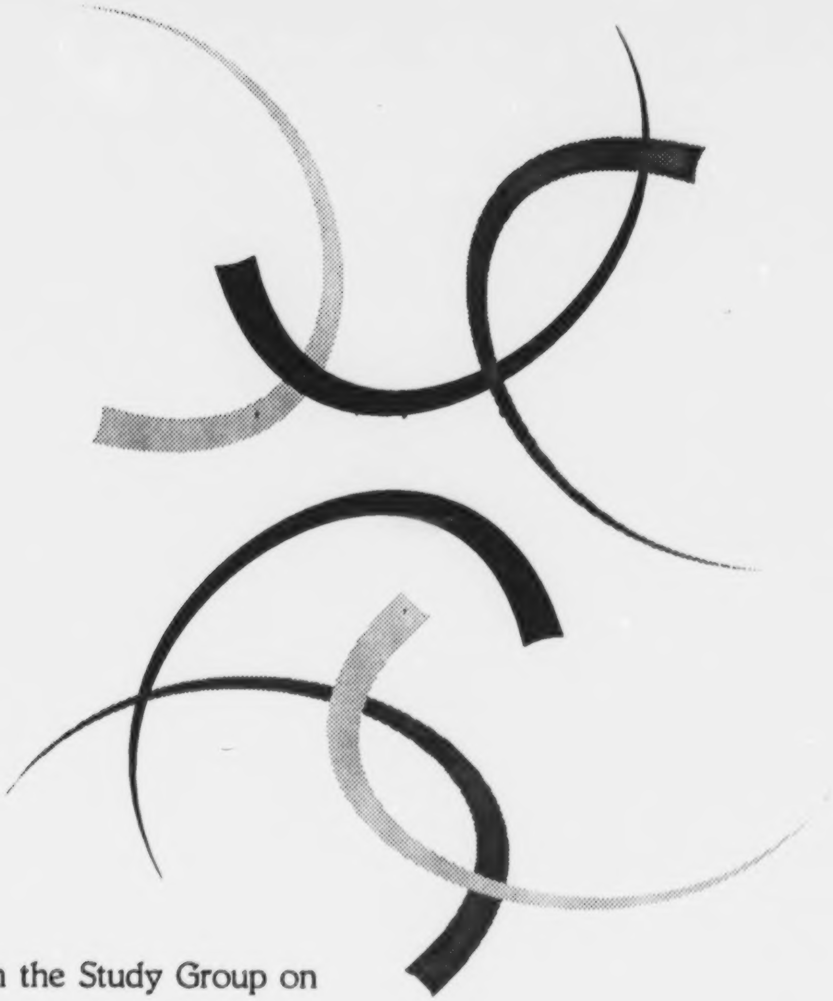

Report from the Study Group on

Cultural Diversity in Rehabilitation

Nineteenth Institute on Rehabilitation Issues
San Antonio, Texas October, 1992

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Chairperson's Comments

The Institute on Rehabilitation Issues (IRI) was founded on the principle "we work best when we work together." Implemented in 1947, IRI and its predecessors (Guidance, Training, and Placement Workshops and the Institute on Rehabilitation Services) have been important sources of information on numerous issues to rehabilitation and related agencies.

The IRI study of Cultural Diversity in Rehabilitation brought together a group of dedicated individuals to communicate, explore different points of view, provide insight, validate impressions, collaborate, and write a document. We wish that everyone could engage in the IRI process. This not being possible, however, the hope of the Prime Study Group is that the outcome of our work will provide direction and stimulation to the readers who serve individuals with disabilities from different cultures, thereby improving the service delivery system.

If we cannot grasp or understand the essence of another person's culture, life, or environment, or if we cannot assure that person an equal access to services that are available, how can we possibly change, empower, or help that individual? This document can only begin to address some of these questions. Hopefully, however, it will suggest ways the reader can develop a better understanding of self and of those who are culturally different.

The Prime Study Group consisted of B. Douglas Rice of the University of Arkansas Research and Training Center in Vocational Rehabilitation (ARTCVR, the university sponsor), Steve Cosgrove of Cosgrove and Associates, Robert Akridge of ARTCVR, Tennyson Wright of the University of South Florida, L. Robert McConnell of the Michigan Rehabilitation Services, Julia O'Brien of the Rehabilitation Continuing Education Program in Region V, Daniel Anderson of the Pacific Basin Research and Training Center, and Ross Sweat of the New Mexico Division of Vocational Rehabilitation. A significant number of individuals with expertise and experience in this area provided consultation and technical assistance to the Prime Study Group as the document was developed. Sincere gratitude is especially extended to Joanne Yamada and Joakim Peter of the Pacific Basin Rehabilitation Research and Training Center for their review of the materials and final editing of the document.

This group of individuals from culturally and professionally diverse backgrounds worked in the true spirit of teamwork to accomplish the assigned task. For their efforts and contributions of work, knowledge, and tenacity to the task, I am sincerely appreciative.

I would also like to express my gratitude to those who participated in the 19th IRI Annual Meeting as Total Study Group Members. Their critiques, feedback, and recommendations made this a better and more useful document to the field of rehabilitation.

On behalf of the Prime Study Group, I extend sincere thanks to Janice Irwin, Mary Drevdahl, Lou Tabor, Sandra Parkerson and Ruth Gullett of ARTCVR for their assistance throughout the duration of the Institute.

It has been my privilege to participate in the IRI process and to have had the honor of serving as this Prime Study Group's Chairperson. It has indeed been a highlight in my rehabilitation career.

J. Alfredo Duarte, Chair
IRI Prime Study Group
Texas Rehabilitation Commission
Austin, Texas

Foreword

The very mention of "Cultural Diversity" results in a reaction from most individuals in some manner of agreement or disagreement. The concerns may seem simple enough in casual discussions, yet, when the topic encompasses the entire realm of cultural diversity the issues become very diverse and extremely complex. This was the experience of the Prime Study Group.

The IRI Prime Study Group represented a diverse membership. Given additional resources, the Group would have welcomed even greater diversity to enhance the study and, in all honesty, to share in the "heat of the battle" as this document developed. In spite of the complexities,, the Prime Study Group recognized the importance of the issue and were determined to do the best job possible with a topic often beset with controversy.

The Prime Study Group soon found that solutions to rehabilitation problems that are acceptable for one group could be unacceptable, even detrimental, to individuals from entirely different backgrounds. They decided there is no correct way to conduct a study on this topic. They chose to initiate a series of studies on specific issues, the results of which could be analyzed, synthesized and integrated into a comprehensive report on cultural diversity that perhaps could find a "general" level of acceptance and agreement.

This Prime Study Group accepted the challenge to develop a usable document on Cultural Diversity in Rehabilitation. The completion of this resource document is to their credit. Further, it is to their credit that many issues of vital concern to rehabilitation and related organizations were identified, if not fully discussed. Others must explore these issues in more depth.

This group realized early in the process that some will disagree and take exception to material in this document. In fact, there were congenial disagreements among members of the group. However, as this project neared completion, the Prime Study Group unanimously agreed that much more remains to be done before people from all cultures are served without prejudice or discrimination, and the field of rehabilitation develops a full appreciation of diversity.

The Prime Study Group was willing to accept the challenge and place themselves on the "firing line" because cultural diversity is such an important issue. I commend this group for the numerous hours above and beyond the normal work day and work week they devoted to this study; for their willingness to undertake and meet a great challenge to rehabilitation; for addressing an issue where there is disagreement and controversy; and for dealing with a topic where more questions exist, by far, than answers or quick solutions.

B. Doug Rice
IRI Coordinator/Sponsor
ARTCVR

Chapter One

Introduction to the Study

Introduction to the Study

Rehabilitation is undergoing major and significant changes as indicated by the following trends: (a) disability rights movement, (b) independent living, (c) the Americans With Disabilities Act of 1990 (ADA), (d) supported employment, (e) the 1992 Amendments to the Rehabilitation Act, (f) career development, (g) community-based services, and (h) the Human Resource Development/Human Resource Development initiative. The confluence of these trends, along with others, and the diversity of the nation's population are changing vocational rehabilitation programs.

This Institute's study focuses on cultural diversity of the population served by vocational rehabilitation. Its proceedings review a complex array of issues related to rehabilitation in ethnically and racially diverse settings. The active involvement of consumers, families, advocates, peer organizations and institutions will increase diversity and add more complexity to the field of rehabilitation, as will the expansion of the scientific, technological and professional knowledge.

Complexity and diversity are closely related concepts. Both diversity and complexity can be destructive or constructive. Diversity can be an adaptive characteristic of groups, organizations and communities. The real challenge for rehabilitation, then, is to understand, value, and use diversity in positive and constructive ways.

Purpose and Scope of the Study

The IRI Prime Study Group's development of this vital study topic represents one effort to influence and guide the process of change. The theme of the document is understanding diversity and the importance of building capacity within organizations and service personnel to effectively serve diverse populations.

The document emphasizes: (a) the expanding cultural diversity of American society, (b) the phenomenon of majority and minority group relations, and (c) issues related to improving the delivery of rehabilitation services. The concensus of the Prime Study Group, after it's initial review of the topic, was to focus on general principles relative to the impact of culture and majority/minority group relations on disability and rehabilitation services. This decision precluded an "encyclopedic" approach to discussing the characteristics of different cultural subgroups in the population. Such an approach was seen as (a) beyond the resources of the study group, and (b) if not adequately addressed, contributing to stereotypical thinking. There was, however, widespread agreement that service providers need to pursue a life-long strategy of learning about cultures--their own and those of the individuals they serve.

The Prime Study Group asked the following questions: "To what extent does having a severe disability place one in a unique culture?" And, "Should the "culture" of disability be included in the present study?" While it was acknowledged that the passage of ADA placed people with disabilities in a protected class and reframed many disability-related issues from a civil rights perspective, the study group members did not agree that persons with disabilities were a cultural group.

The study group chose not to include a discussion of the "culture" of disability in this report. Rather, the group focused on culture as related to race and ethnicity and the need for: (a) a better understanding of the general concept of one's own culture, (b) a better understanding of the culture of others, and (c) how cultural diversity affects the disability service delivery system.

The study group members believe there is a great need for an awareness of one's own culture as well as the other cultures with which one interacts. Critical culturally-determined assumptions and myths shape people's attitudes and behavior in general, and toward people with disabilities in particular. Those assumptions must be investigated. Because traditional appeals to reduce prejudice and discrimination and increase tolerance have had limited success, new approaches are needed. Diversity management and diversity training which emphasize the positive advantages of diversity are proposed.

Intended Audience

This document, *Cultural Diversity in Rehabilitation*, is intended for persons involved in the disability service delivery system. Especially targeted are those in leadership roles at all levels of the vocational rehabilitation service delivery system. The document encourages readers to expand their cultural awareness, and suggests strategies for improving rehabilitation service effectiveness.

The study speaks most directly to upper level managers who have the most power to affect change--those in state rehabilitation agencies, Rehabilitation Services Administration, the National Institute on Disability and Rehabilitation Research, developmental disabilities programs, mental health programs, and consumer organizations.

Overview of Remaining Chapters

Chapter II reviews the major barriers to improving services and the quality of life for people with disabilities to whom society (the majority culture) assigns minority group status. Barriers are described at the societal, professional, organizational, and service provider levels.

Chapter III is an overview of the history of rehabilitation's response to persons with disabilities from culturally diverse backgrounds. This historical review shows that the prevailing strategy of "compensatory education and training" and promotion of "tolerance" has achieved modest outcomes at best.

Chapter IV focuses upon a model for developing a culturally responsive rehabilitation organization. Given the influence of the state rehabilitation agencies on the total disability service delivery system, the emphasis is appropriate. A human resource development and human resource management framework is systematically applied to various elements of rehabilitation organizations.

Chapter V focuses on methods and strategies for delivering rehabilitation services. Given the leadership and support of culturally responsive organizations, the cultural competence of individual service providers becomes the major determinant of success or failure. This chapter provides a review of those skills, attributes, and approaches that research and clinical experience have shown to be important in all helping relationships. Several case scenarios are also provided to show how cultural issues are involved in this process.

Chapter VI provides recommendations for (a) achieving culturally-responsive organizations, and (b) developing culturally-competent rehabilitation practitioners. Specific activities are suggested to help rehabilitation agencies, or other service provider organizations, to put into practice the organizational development model outlined in Chapter IV.

Chapter VII provides a compendium of informational and technical assistance resources. Almost every professional journal in the field of rehabilitation has, during the past two years, published a special edition on cultural diversity. The topic has received a great deal of attention in business and industry as well as from leaders with both major political parties.

Chapter Two

Barriers to Effective Services

Barriers to Effective Services

Objectives

1. To present some of the barriers to effectively serving culturally diverse persons with disabilities
2. To describe the barriers within the context of societal, professional, organizational, and individual service providers
3. To present questions that guide readers through an assessment of barriers to effective rehabilitation services

Summary

This chapter discusses some of the barriers to effectively serving culturally diverse people with disabilities. For the purpose of discussion, barriers to effective services are organized in terms of societal, professional, organizational, and individual service providers. The presentation of societal barriers focuses on the historical treatment of minorities, and prevailing values versus minority values.

The discussion of professional barriers is delimited to cultural biases in research and theory. Ethnocentric biases influence research questions, methods, and the interpretation of results. Given those biases, inadequate progress has been made in the development of a body of knowledge supporting effective service delivery to persons from minority cultural groups. The strengths of the vocational rehabilitation services (interdisciplinary and applied) for persons from minority cultural groups are offset by the continued use of old theory (cultural deviance) that portrays those persons as "deprived and disadvantaged." New theory, supported by culturally appropriate research, is required of the VR profession.

Organizational barriers to effective service impact on all clients, including those from minority groups. General organizational effectiveness may be assessed in relation to: (a) the existence of clear statements of purpose, goals and objectives, (b) clear description of service function, and (c) a structure that supports purpose and function. A poorly organized agency is a barrier to effective service. If an organization is to effectively serve people from minority groups, organizational purpose, function, and structure must explicitly support that intent.

Many barriers to effective VR services can be overcome by culturally skilled service providers. Culturally skilled counselors (a) develop self-awareness, (b) understand the world view of others, and (c) develop and practice appropriate service strategies. However, self-awareness and the development of an awareness of others are difficult processes. The effective counselor is one who accepts the challenge and is willing to confront his or her own ethnocentrism and related prejudices.

Discussion

Barriers to Effective Services

"At issue here is not a patronizing notion of understanding the Other, but a sense of how the self is implicated in the construction of Otherness" (Giroux, 1992, p. 32). As individuals and as representatives of our society's professions and institutions, we have "constructed" minorities. By doing so, we have also constructed barriers to effectively serving those from minority groups. Barriers are organized here in the following categories: (a) societal, (b) professional, (c) organizational, and (d) service provider. Interactions among those categories are also discussed. Service providers, for example, are influenced by societal, professional and organizational barriers.

Definitions of Key Terms

Culture. Culture, as Downs (1975) suggests, has been defined hundreds of ways. There is no one best or universally accepted definition. Culture may be defined as shared knowledge, beliefs, and values. One's culture defines a particular view of reality and determines acceptable behavior. American culture, or the majority culture, is commonly defined as the knowledge, beliefs and values of the white, male, middle class (Stewart & Bennett, 1991). Minority cultures include those who, because of cultural characteristics that are different from the majority, receive unequal and pejorative treatment. In this discussion, the use of the term minority is limited to racial and ethnic groups.

Prejudice. Prejudice is defined as an attitude that predisposes knowledge, beliefs and behaviors regarding diverse groups. Dworkin and Dworkin (1982) describe prejudice as learned "mental images" that influence thoughts, feelings and behavior. They suggest that, for individuals from the dominate culture, prejudice serves the following functions: (a) gives meaning to cultural group interactions; (b) maintains class distinctions, including superordination for economic, social and political gain; (c) permits expression of dominate values; and (d) maintains social distance. Frequently prejudice is disguised and expressed as euphemisms, metaphors and code words which carry double meanings.

Discrimination. Where prejudice reflects attitude, discrimination implies behavior or, more specifically, differential and pejorative treatment. Discriminatory treatment of individuals and groups may include: stereotyping, avoidance, physical attack, subjugation, and extermination. Examples of all forms of discriminatory behavior can be found in America's history. Today, discriminatory behavior continues and includes an alarming increase in the number of violent physical attacks on minorities.

Racism. Racism is defined as the cumulative effects of attitudes, beliefs, behaviors and the majority's power to act which results in the oppression of minorities (Katz & Taylor, 1988). On a daily basis, our news media report stories about overt societal racism. Much less discussed and understood are the forms of racism that are barriers to serving individuals with physical and mental disabilities who are from minority groups.

Societal Barriers

Societal barriers to effective service delivery include factors that influence the foundation of our knowledge, beliefs and behaviors regarding minorities. As discussed in the following chapter, societal barriers contribute to and reinforce the other categories of barriers.

In this chapter the discussion of societal barriers includes the historical treatment of minorities, prevailing versus minority values, and other selected factors such as limited public resources.

History. The history we have come to know has been shaped by the beliefs and values of America's dominate culture and includes incomplete and often derogatory information about minority groups. *That* history has influenced the (a) development of the counseling profession, (b) the organization and delivery of rehabilitation services, and (c) the way service providers relate to clients.

A non-prejudiced understanding of the historical treatment of minorities is needed to understand the societal barriers that impact on serving individuals with disabilities from minority groups. Our lack of knowledge--or our selective knowledge of history--is a barrier to understanding and valuing the contributions made by America's diverse racial and ethnic groups. Weigel and Howes (1985) suggest that our history reflects prejudice and racism which are "anchored in the mainstream of American tradition." Katz and Taylor (1988) state that "racism has been part of the American fabric since our nation's founding."

Awareness of prejudicial historical information and patterns of thinking is particularly difficult for Americans (Stewart & Bennett, 1991). Our lack of awareness affects our perceptions, judgments and evaluations of minorities (Ishisaka, 1992). Cultural differences are often interpreted as characteristics of personality, not outcomes of a history of prejudice and racism. As an example, Omatsu (1992) discusses stereotypes "routed in history" that continue to influence employer and labor union policies. He suggests that stereotypes such as the "clannishness" of Asian-American workers and "their aspirations for business ownership" can be traced to anti-Asian racism which, at the turn-of-the-century "protected American jobs."

A lack of understanding of the history of minority groups perpetuates prejudicial barriers. Providers of rehabilitation services need to understand the role that history has played in determining where persons from minority groups live and work, and how they access and use health, education, and human services.

Values. Prevailing "American values" can be identified and contrasted with the value orientations of minority groups (Bowers & Flinders, 1991; Ponterotto & Casas, 1991; Walker, 1991). This chapter briefly discusses dominant and minority value differences such as those exemplified by individualism, competition, and achievement. Persons from some minority groups, when compared to the majority, tend to place greater value on the family and/or group than on the individual, cooperation rather than competition, and relationships rather than achieving a particular objective.

Differences in value orientations such as those noted above are not considered in the determination of social policy. Dominant values serve as the norm. Policymakers who are from the majority culture make decisions based on their own values, and assume that those values are shared by others. Such assumptions serve as an "invisible veil" that prevents recognition of important minority cultural differences (Sue, Arredondo, & McDavis, 1992).

Dominant cultural values related to individualism, self-reliance, and work are evident in rehabilitation legislation, policies, and procedures (e.g., individualized written rehabilitation program plans, independent living programs). Individuals from minority cultures, however, may not place as high a value on individualism and self-reliance as individuals from the dominant culture. For example, vocational rehabilitation counselors serving persons who live in the Pacific Basin have found that Pacific cultures often de-emphasize the individual and value the affiliative response in decision-making (Fitzgerald & Anderson, 1992). Leung (1992) suggests that some Asian and Pacific cultures, when compared to the majority culture, place family and group responsibilities before work responsibilities.

Weigel and Howes (1985) discuss differences between prevailing and minority values which are particularly troubling. In situations such as affirmative action and school integration, the group-oriented values and interests of minorities clash with the traditional majority values of individualism and choice. Weigel and Howes (1985) believe that such situations can result in "symbolic racism" or the "blending of old prejudice with traditional American values." Under the rubric of respectable prevailing values, members of the majority culture justify discriminatory behavior. For example, "individual choice" may be used to justify de facto school or job segregation, and serve as an educational or employment barrier to members of minority groups.

Other factors. A variety of other social forces serve as barriers to effective rehabilitation service delivery to persons from minority groups. Some of these forces have been described as "centrifugal" forces that segment our society by "distinguishing people from each other" without emphasizing our common needs and interests (Klein, 1992).

Examples of social forces that complicate the delivery of effective services include:

1. Growing economic differences and social disconnections between majority and minority groups, among different minority groups, and within minority groups (i.e., generational and acculturational differences);
2. Increasing distance between those making decisions and those impacted by decisions; and
3. Decreasing public (federal and state) resources for human services.

Compounding the barrier of decreasing resources are increasing numbers of individuals living in poverty, the complexities of related economic issues (e.g., structural changes in the private sector and public sector budget deficits) that impact on the funding of human services, and divergent views regarding both the value and funding of human services.

Professional Barriers

Professions are, in part, a reflection of the beliefs and values held by society. In turn, the beliefs and values of professions impact on service organizations and individual service providers. A full discussion of professional barriers related to effective services should include a number of issues: cultural bias in research, cultural bias in theory development, and inadequate involvement of minorities in research and professional preparation.

Some issues related to professional barriers, such as the history and philosophy of counseling, are discussed in the following chapter. Also, issues related to service delivery and personnel development are addressed in subsequent chapters. The discussion of professional barriers contained in this chapter focuses on factors related to research and the development of theory.

Research. Researchers are often unaware of the racial and cultural misperceptions they bring to the field of vocational rehabilitation counseling. Those inaccurate perceptions and associated ethnocentric biases influence what research questions are asked; how studies are designed; which research studies are funded; and how results are interpreted, disseminated and applied.

In addition to ethnocentric biases, there are other barriers to effective research. Kumanyika and Golden (1991), for example, have identified the following problems associated with conducting race/ethnic research: (a) validity of racial/ethnic classification, (b) methodological errors associated with population sampling, and (c) misinterpretation of findings.

Too often, unscientific methods of racial/ethnic classification are used in research. Even when more scientific genetic bases for racial/ethnic classification are used, there can be problems associated with classification. For example, in Hawaii, where approximately 31% of the state's population is of mixed race/ethnicity, researchers are challenged by the methodological issue of classification.

Also challenging to researchers are the methodological problems associated with sampling. Again, using Hawaii as an example, vocational rehabilitation researchers have found sampling errors related to ethnicity and service utilization. Population and service utilization data suggest that specific ethnic groups are underutilizing vocational rehabilitation. Researchers are now asking: Are there differences in need among ethnic groups? If needs differ among groups, are services underutilized by particular ethnic groups? If services are underutilized, why? Is there a cultural mismatch between those in need and service strategies used?

Interpretation of racial/ethnic population differences can be particularly problematic. Misinterpretations become barriers to the development of new knowledge and more effective services. As Kumanyika and Golden (1991) suggest, genetic explanations of differences can play into stereotypes and even be interpreted as reasons for not addressing environmental risk factors. On the other hand, environmental explanations of population differences may be viewed as evidence of negative life-style practices which are the responsibility of the individual, not service institutions. Yet, others may view environmental explanations of racial/cultural differences as indications of institutional racism.

Native Americans and Pacific Islanders, when compared to other groups, have exceptionally high rates of diabetes and related disabilities. Is this problem to be interpreted as a genetic problem with little to be done? Or is the problem environmental (diet)? If it is environmental, are individuals to be blamed for negative life-style practices? Or should service institutions be held responsible for not providing appropriate health and educational services?

The beliefs and values of researchers will shape the answers to the questions noted above as much or more than any "objective data" that might be collected and analyzed.

Theory. Vocational rehabilitation counseling has historical links to the fields of medicine and psychology. The strengths of the vocational rehabilitation profession, though quasi-theoretical (Cottone & Emener, 1990) are in its interdisciplinary and applied orientations. However, those characteristics may also be weaknesses and be associated with barriers to effectively serving persons from minority groups.

Old borrowed theories related to race and ethnicity must be revised. As discussed in the next chapter, terms such as "culturally deprived," "culturally disadvantaged" and "minority problems" are indicative of the ethnocentrism associated with those theories. "Harmful historical models" (Sue, Arredondo, & McDavis, 1992) that portray people from minority groups as inferior, serve as barriers and prevent the development and use of more appropriate theory.

Three perspectives of racial/ethnic differences--cultural deviance, cultural equivalence, and cultural variance--have been suggested (Pollard, 1992). The deviance model, as briefly discussed above, interprets differences in a negative or deficit-oriented manner and is a barrier to developing more effective services. The other two perspectives make a more positive contribution to building theory and the development of effective service models. Cultural equivalence emphasizes the similarities among diverse groups. Cultural variance is a "celebration of pluralism and the strength of diversity" (Pollard, 1992).

Racism and its influence on theory and service delivery are beginning to be addressed (Katz & Taylor, 1988). However, as Ponterotto and Casas (1991) point out, the counseling profession is far from shedding its cultural biases in developing theory.

Davis (1992) proposes a number of research/evaluation strategies that may help to ensure appropriate research design and interpretations of results as well as to facilitate the development and testing of theory regarding services for minorities. Those strategies include the following:

1. Culture-Sensitive Researchers/Evaluators: Research and evaluation teams must include members of the minority communities being studied.

2. Variable Exchange: The conceptual appropriateness of a race/ethnicity variable should be validated. Exchanging different conceptual meanings is a useful method for validation. For example, is race being used as a biogenetic variable or as a proxy variable for environmental (i.e., social and economic) variables?

3. Contextual Analysis: Race/ethnic data analysis and the interpretation of results must take into consideration the social context of the subjects studied and/or the program being evaluated.

4. Within- and Between-Group Comparisons: Analysis should include both within- and between-group comparisons. Often, race/ethnic research results overemphasize between-group differences and underemphasize within-group differences.

5. Feedback of Interpretations: Given the involvement of persons from the groups studied, inaccuracies in interpretations may be detected before dissemination.

Organizational Barriers

Succeeding chapters focus specifically on vocational rehabilitation organizations. The discussion below addresses barriers as they relate to general organizations: purpose, design and effectiveness.

Purpose. All organizations have a purpose. Statements of purpose for federal/state funded rehabilitation programs may be found in enabling legislation. State VR agencies also develop goals and objectives that reflect organizational purpose. However, if goals and objectives do not clarify purpose and address the needs of minority populations, these needs may not be addressed.

Organizations can have de facto purposes that become barriers to effective service delivery. Public organizations may function as secure employment systems which can promote a "civil-service mentality." Such a mentality can become a barrier to effective service delivery if, for example, negotiated working conditions are designed to maximize employee benefits rather than promote service delivery. Individuals from a particular cultural group may be most effectively served through strategies (e.g., outreach, community-based programs, flexible service hours) that conflict with standard office hours and work locations that are the most convenient for employees.

Unclear and/or inappropriate purpose and inadequately developed organizational goals and objectives are barriers to effective service delivery.

Design. Design refers to the process by which a structure is created to carry out the organizational purpose. Models of organizational design include "classical" concepts of scientific management and bureaucratic theories as well as more current concepts (e.g., systems, decentralized "strategic units," "matrix" structures) that respond to specific situations and the effective integration of organizational purpose and function.

The functions of rehabilitation agencies include client identification, assessment, planning, and service delivery. For each function and each cultural group, potential barriers can be identified. As examples, the following barriers suggested by Uba and Sue (1991) may impact on the identification of persons from a given minority group: (a) language differences, (b) fears and suspicions, (c) cultural inhibitions against seeking help, and (d) differences in conceptions of help.

Effective assessment and service planning must address the barriers listed above as well as cultural differences in the expression of problems, and coping with problems (e.g., stoicism, resignation). Service delivery strategies may or may not be culturally appropriate for each group served. Barriers associated with the availability, accessibility, and appropriateness of service models must be assessed and addressed. Some individuals may be effectively served using "mainstream" strategies. Others may be best served in separate service options that address unique language and/or cultural needs.

Organizational Effectiveness. Organizational ineffectiveness is a barrier for all, including those from minority groups. Effective organizations assess needs and, based on those needs, develop: (a) a clear statement of purpose and goals, (b) a clear description of function (i.e., how the organization will accomplish its purpose), (c) a structure for using organizational resources (e.g., division of labor), and (d) descriptions of roles, activities and tasks.

Organizational effectiveness can be assessed and barriers identified. The following questions may be asked in the assessment of purpose. Are the goals and objectives of the organization based on the needs of the target population? If not, is that organization misdirecting resources? Are the needs of all segments of the target population, including minorities, being addressed?

Dosher (1978) suggests that public agencies can loose sight of the needs of those to be served and therefore loose sight of their intended purpose. Such organizations develop barriers related to misdirection. Most of us can think of an organization that appears to be more interested in maintaining an existing power structure than changing to meet new or different needs. Old inflexible organizations, particularly those using bureaucratic structures, can serve as barriers to effectively serving minority populations.

Inappropriate emphasis on service provider roles and activities can also pose barriers to effective service delivery. For example, Anderson (1985) has described a community-based rehabilitation organization that over-emphasized a specific training role and under-emphasized the assessment of need and the development of a clear purpose. He described staff as being "very good" in the role of training persons in a particular vocational skill. However, the vocational skill being taught was not needed (i.e., was not appropriate in light of available employment opportunities). Thus, "very good" training in an inappropriate vocational skill was a barrier to effective rehabilitation.

Service Provider

Finally, the focus is on barriers to effective rehabilitation that are associated with the individual rehabilitation service provider. Societal, professional, and organizational factors all impact on the service provider. However, this discussion will only address the service provider's cultural self-awareness, and awareness of the cultures of others.

In general, individuals are not aware of their own cultural values and the assumptions upon which these values are based. Most people remain oblivious to their cultural backgrounds as well as fail to understand the world views of others. As Ishisaka (1992) suggests, the "preconscious" nature of culture results in ethnocentricity.

Sue, Arredondo, and McDavis (1992) believe that the majority of counselors are not culturally skilled. The culturally skilled counselor must develop self-awareness, attempt to understand the world view of others, and actively develop and practice appropriate service strategies.

Self-awareness. Awareness of one's culture is a difficult task (Ishisaka, 1992). The depth of cultural embeddedness cannot be made fully explicit (Bowers & Flinders, 1991). Stewart and Bennett (1991) suggest that it is particularly difficult for Americans from the majority culture, to develop cultural awareness. Americans from the majority culture assume that their beliefs and values are "normal and right," take for granted their cultural patterns, and tend to overgeneralize and stereotype minority cultural patterns. Limited self-awareness can be a barrier in the development of effective relationships with co-workers and clients from other cultural backgrounds.

Cultural sensitivity requires a serious and sustained effort. The difficulty associated with developing cultural awareness is, itself, a barrier. One must be willing to take on the "formidable task" described by Ishisaka (1992), that is, to confront one's own ethnocentrism and related prejudices.

Awareness of Others. There is no way to completely understand one's own culture, much less understand the worldviews of individuals from hundreds of other cultures and sub-cultures. The illusion that one can easily do so "places blinders on the individual and invites inflexibility" (Stewart & Bennett, 1991). Once more, individual cultural differences must be understood in relation to differences in socioeconomic status, religion, age, gender, geographic region, acculturation, and identity commitment (Ponterotto & Casas, 1991).

The difficulty of developing a cultural awareness of others can be used as a barrier. That is, used as a rationale for not even attempting greater awareness. Some might suggest that cultural awareness and sensitivity are so difficult to achieve that they, as individuals, need not be held responsible. However, by not addressing this admittedly difficult barrier, service providers may be engaging in "cultural oppression" and using unethical and harmful practices (Sue, Arredondo, & McDavis, 1992).

Although a formidable task, the barriers to cultural awareness can be overcome. Sue, Arredondo, and McDavis (1992) suggest that a three-dimensional framework which focuses on beliefs and values, knowledge, and skills be used in the development of a culturally skilled counselor. Such a model can be used in developing a better understanding of one's own culture, understanding the worldviews of others, and developing more appropriate service strategies.

Walker (1991) proposes that counselors use a "cultural template" which can guide the service provider through a process of assessing beliefs and critical value differences. Areas where majority and minority beliefs and values may differ include world view, family boundaries, quality of life, importance of religion, meaning of work, meaning of education, decision-making style, belief in change, and response to change (Walker, 1991). Others (Hall & Hall, 1990) from the field of intercultural communication emphasize cultural differences related to context (the information that surrounds events), space, time, speed (with which relationships are developed), information flow, and rules (and rituals).

Weigel and Howes (1985) review strategies that have been found effective in prejudice reduction. Those strategies include: (a) equal status in contact situation, (b) supportive norms, (c) repeated exposure, (d) interpersonal intimacy, (e) common goal, (f) successful task accomplishment, and (g) experiences that generalize.

Implications and Conclusions

Society has constructed barriers which keep service providers from effectively serving those from minority groups. As a result of these barriers, inadequate progress has been made in service delivery to persons from minority cultural groups. Development of self-awareness and an awareness of others are different challenges which must be met in order to provide more effective services.

For the purpose of discussion, barriers to effective VR services are organized in terms of the following: (a) societal, (b) professional, (c) organizational, and (d) individual service provider. The presentation of societal barriers focuses on the historical treatment of minorities, and prevailing versus minority values. A non-prejudicial view of the history of minorities and of majority/minority value differences is necessary in order to develop an understanding of barriers to effective services.

The discussion of professional barriers is limited to cultural biases in research and theory. Ethnocentric biases influence research questions, methods, and the interpretation of results. Given those biases, inadequate progress has been make in the development of a body of knowledge supporting effective service delivery to persons from minority culture groups. The strengths of the VR services (interdisciplinary and applied) for persons from minority culture groups are offset by the continued use of old theory (cultural deviance) that portrays those persons as "deprived and disadvantaged." New theory, supported by culturally appropriate research, is required of the VR profession.

Organizational barriers to effective service impact on all clients, including those from minority groups. General organizational effectiveness may be assessed in relation to the existence of clear statements of purpose, goals, and objectives; a clear description of service function; and a structure that supports purpose and function. A poorly organized agency is a barrier to effective service. If an organization is to effectively serve people from minority groups, organizational purpose, function, and structure must explicitly support that intent.

Many barriers to effective VR services can be overcome by culturally skilled service providers. Culturally skilled counselors develop self-awareness, understand the world view of others, and develop and practice appropriate service strategies. However, self-awareness and the development of an awareness of others are difficult processes. The effective counselor is one who accepts the challenge and is willing to confront his or her own ethnocentrism and related prejudices.

Readers may wish to assess their awareness of minority groups, how they obtained information about minority groups, their agency's commitment to serving people from minority groups, and their agency's use of culturally appropriate service strategies. Self-assessment questions follow.

I. What do you know about the minority groups in your community?

    1. What are the minority culture groups in your community?

2. Select three groups. What were the historical factors that influenced where persons from each group (a) lived, (b) received an education, and (c) obtained employment?

3. How do those historical factors influence where members of the minority groups live and work today?

4. How do today's residential, educational, and employment opportunities differ (a) among the minority groups and (b) between each minority group and the majority population?

II. How did you obtain your knowledge of minority groups?

1. How did you obtain your knowledge about each selected minority group?

2. How do you know if your knowledge of each group is accurate?

3. Have you, in your professional training, received any formal instruction in (a) your own culture (e.g., beliefs and values), and (b) cultures other than your own?

4. Do you work, socialize, and/or live with individuals from cultural backgrounds other than your own?

5. Does your knowledge from personal experiences match what you have learned through formal training?

III. Has your agency made a commitment to serve people from minority groups?

1. Does you agency value cultural diversity?

2. Are there specific agency policies regarding the employment of persons from minority groups?

3. Are there specific agency policies regarding the provision of services to individuals from minority groups?

4. Does your agency's performance reflect stated policies (e.g., diversified personnel, diversified clientele)?

IV. Are your agency's service strategies appropriate for persons from various minority groups?

1. Does your agency's physical environment reflect the culture(s) of those served?

2. Does your agency use strategies such as: (a) indigenous intake workers, (b) culture brokers, (c) bilingual and/or bicultural counselors, and (d) client, service-provider matching?

3. Do service providers use appropriate service strategies such as culture-relevant assessment, and culture-specific intervention service models?

Have you embarked on a planned program for (a) developing cultural self-awareness, (b) understanding the culture of others, and (c) promoting and/or practicing culturally appropriate vocational rehabilitation service strategies?

The information in this chapter has, hopefully, alerted VR to some of the factors (societal, professional, and organizational) that serve as barriers to effective service delivery. Concerted efforts must be made to increase awareness of self and of culturally diverse populations. By concentrating on cultural self-awareness, perhaps professionals can become a positive force for organizational, professional, and community change toward removing barriers to effective services for individuals with disabilities from culturally diverse backgrounds.

Chapter Three

Historical and Philosophical Background of Cultural Diversity in Rehabilitation

Historical and Philosophical Background of Cultural Diversity in Rehabilitation

Objectives

1. To provide a historical and philosophical perspective of the issues underlying cultural diversity in rehabilitation
2. To review the history of the rehabilitation of individuals with disabilities from different cultural backgrounds
3. To present the philosophy of rehabilitation in the 1990s as related to the issues underlying cultural diversity

Summary

A major challenge facing rehabilitation today is the effective provision of appropriate services to a diversified population. This chapter will review how rehabilitation has dealt with cultural diversity in the past.

A review of the rehabilitation literature over the past 25 years reveals a philosophical shift from perceiving minority culture as a "disadvantage" to valuing diversity. The literature also indicates that problems associated with serving diverse populations have, for some time, been identified and discussed. However, effective solutions to those problems have not been developed and implemented.

Discussion

A review of the historical issues underlying "cultural diversity in rehabilitation" would suggest that one begin by reflecting on the views of society as captured by Riessman (1967) who noted:

> Many people see only the negative environmental conditions that surround the disadvantaged, and they believe that this is the culture. They feel that it is democratic and liberal to "accept" this culture (just as another way of life). But understanding of this culture must include a genuine appreciation of the positives that have arisen out of effort, however insufficient at times, to cope with the difficult environment.

As Riessman suggests, all too often society's view of minorities depicts deprivation and emphasizes weakness. "One of the great difficulties with formulations like 'culturally deprived,' 'disadvantaged,' 'culturally handicapped,' 'impoverished,' etc., is that they connote inadequacy, rather than present a rounded picture of the culture which would have to include strengths as well as deficiencies." (Cited in Ayers, 1967, p. i)

People with disabilities, who are members of minority culture groups, may be seen as both "disadvantaged" and "disabled." The view that these individuals must have "strengths" as well as "weaknesses" is uncommon.

A devaluation of people with disabilities who are members of minority culture groups has thwarted the overall success of the rehabilitation system in the United States. A review of the literature reveals that, in spite of some progress, these historically held views continue to have a detrimental impact on rehabilitation services.

Rehabilitation in the 1960s

Ayers (1967) noted that, between the early 1900s and the mid 1960s, the field of vocational rehabilitation experienced tremendous activity. Yet, Ayers believed that in the mid 1960s we were only on the threshold of significant change.

Amoung the areas which were experiencing significant change in the 1960s was the system of delivering rehabilitation services to people who were members of minority culture groups or, to use the terminology of the time, the "socially disadvantaged." Ayers (1967) stated:

> Vocational rehabilitation programs have been relatively successful in serving the physically, mentally, and emotionally handicapped. As a result of the enactment of the Vocational Rehabilitation Amendments of 1965, however, eligibility for rehabilitation services provided by state vocational rehabilitation agencies was extended to the culturally [socially] disadvantaged. It is incontestable that state vocational rehabilitation agencies have moved very slowly in approaching this new disability group. Two salient factors--the lack of knowledge and development of diagnostic criteria, and the lack of experience with this disability group--seem to have influenced the provision of vocational rehabilitation services to the culturally [socially] disadvantaged. (p. ii)

The Mankato State College Conference

In an effort to address the problems noted by Ayers, a conference on "Rehabilitating the Culturally Disadvantaged" was held at Mankato State College in 1967. The purpose of the conference was to provide state directors and selected administrative personnel from the Rehabilitation Services Administration, Region IV, with the following: (a) the essential information relative to the characteristics and problems of, as well the methods for, rehabilitating the culturally disadvantaged; (b) an opportunity to cooperatively develop criteria for utilization by state vocational rehabilitation agencies in diagnosing cultural deprivation; and (c) an opportunity to delineate and develop procedures for increasing the provision of vocational rehabilitation services to the culturally disadvantaged (Ayers, 1967).

Ayers (1967) listed the following recommendations made by conference participants:

1. "The rehabilitation counselor who serves culturally disadvantaged clients should be skilled in interviewing and relating...and should be trained to understand (and possibly use in diagnostic sessions) the language patterns..."(p. 80)

2. "The use of counselors who attempt to communicate specifically with these individuals." (p. 81)
3. "Rehabilitation services located within an urban renewal housing project, which provides a 'captive' group of potential rehabilitation clients who are culturally advantaged." (p. 81)
4. "Involvement with community action programs, public education, and enlisting the active support of local civic and religious groups to help supply immediate needs for transportation, funding, etc." (p. 82)
5. "The use of counselor aides to provide nonprofessional services of a routine or supportive nature." (p. 82)
6. "...additional professional staff members with particular enthusiasm for work with the culturally disadvantaged must be hired by local rehabilitation agencies." (p. 83)
7. "New techniques should be developed and encouraged with boldness and imagination." (p. 91)

Several gaps in services were also identified by conference participants. Among them were:

- "The lack of trained professional rehabilitation counselors with interests and skills in working with the culturally disadvantaged"
- "The negative labels applied to the culturally disadvantaged, which would appear to limit their use of existing services."
- "The gap in communication caused by language and dialect differences between college-trained counselors and the hard-core disadvantaged..."
- "The need for public relations work and increased publicity on the role and services of vocational rehabilitation counselors."
- "The lack of involvement in depth (understanding) with the culturally disadvantaged, which might be closed through improved training programs." (Ayers, 1967, p. 82)
- "...The negative labels (often used in diagnosis) may well constitute a gap in offering services to the culturally disadvantaged." (Ayers, 1967, p. 90)

The use of dated terms aside, a review of these recommendations and gaps reveals that the participants were very aware of the obstacles to service delivery and provision of more effective rehabilitation services to the culturally disadvantaged. Despite their astuteness, the problems which were evident then are even more prevalent today.

NRA Publication on the Culturally Disadvantaged

During the same era as the conference on "Rehabilitating the Culturally Disadvantaged," the National Rehabilitation Association (NRA, undated) published Ethnic Differences Influencing the Delivery of Rehabilitation Services in which Kreimer (Undated) asserted that:

> It is a recognized fact that most professional workers in rehabilitation are far from adequately prepared to work affectively [effectively] with many of the socially and culturally disadvantaged people who are now their clients. This is particularly true of disadvantaged people who happen to be members of minorities and who face the additional problems associated with minority status." (p. 5)

He noted that NRA's "Ethnic Difference Series" was intended to sensitize the rehabilitation practitioner to ethnic characteristics, the different needs and values of members of several minority groups, and the need for new insights into the problems and attitudes of these groups. Clearly, the problems identified by NRA and Kreimer were intended to sensitize the profession to the challenges faced by people with disabilities who are members of multi-cultural groups. Also, it was intended to draw attention to the lack of preparation which rehabilitation professionals were receiving at the time.

Other Efforts in the 60's

Attempts to develop new and innovative approaches to providing rehabilitation services to people with disabilities during the 1960s were addressed by Kunce and Cope (1969) in Rehabilitation and the Culturally Disadvantaged. They noted that the primary definition of rehabilitation was to maximize an individual's potentialities by focusing on counseling strategies, program outcomes, and delivery systems. They also indicated that the rehabilitation strategy involved "...first...changing the disadvantaged themselves and second, in providing more appropriate and efficient services to them" (p. 203). Kunce and Cope (1969) made several assumptions that served as the foundation for service delivery in the 1960s. They suggested that:

> ...the clientele served by welfare, rehabilitation, and employment service will vary along a continuum of dependency. That is, welfare clients could be defined in terms of criteria that illustrate their dependency on society for basic subsistence; rehabilitation clients, on a need for transitory but substantial subsistence and assistance until they can reach a goal of independence; and employment service clients, on a need for and ability to benefit from immediate and direct placement into competitive employment or training programs. (p. 204)

In an effort to analyze the effectiveness of programs, Kunce (1969) reviewed several government programs. As indicated in Table III-1, his analysis offered a sketch of programs and their approaches for increasing the employability of the unemployed and the underemployed (culturally disadvantaged).

It is important to note the different approaches of various programs designed to enhance the welfare and status of "underprivileged" individuals. For example, public and private agencies such as the Vocational Rehabilitation Administration (now the Rehabilitation Services Administration [RSA]) and Jewish Vocational Service employed, as a primary approach, "change the individual." Other programs such as the Office of Economic Development and the Department of Public Welfare employed, as a primary approach, "promote and develop jobs; place individuals in existing jobs; and change the individual." Programs sponsored by the Department of Labor such as Neighborhood Youth Corps employed, as a primary approach, "provide jobs; select people for specific

Table III-1. Programs Reviewed

Major Sponsor	Specific Examples	Primary Approach
Vocational Rehabilitation Administration (VRA)*	Los Angeles, CA Pruitt-Igoe, Vermont	Change the individual**
Private	Jewish Vocational Service, Minneapolis Rehab Center, Oak Glenn Youth Camp	Change the individual**
Office of Economic Opportunity	Job Corps, Community Action Programs	Promote and develop jobs. Change the individual**
Department of Welfare	Title V Programs	Place individuals in existing jobs. Change the individual**
Department of Labor	Neighborhood Youth Corps (NYC), Manpower Development and Training Act, National Alliance of Businessmen, United States Employment Service	Provide jobs. Select people for specific jobs (or training).
Miscellaneous	Relocation of workers, changing employment requirements, New Careers, Project 100,000	Changing opportunity structure

Reprinted from J. T. Kunce & C. S. Cope. (Eds.) (1969). Rehabilitation and the culturally disadvantaged. Columbia, MO: The University of Missouri-Columbia, Regional Research Institute.

jobs (or training)." Other miscellaneous programs advocated "changing opportunity structure." While each of these programs advocated a similar or different primary approach, Kunce (1969) concluded that "We still cannot clearly define what approaches are best suited for the immediate needs of many different kinds of people living in poverty" (pp. 163-164). He further stated that:

> It is evident that many programs are naively assuming that they can cope with complex problems of helping people enhance their educational and economic opportunities. These attitudes can easily result in stereotyped and rigid approaches of treating groups of individuals in assembly line fashion and ignoring each person's own individuality, special problems, needs, and interests. The scarcity of good research and lack of

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* now Rehabilitation Services Administration (RSA)

** would fit with social-humanitarian emphasis

> adequate assessment has contributed to a seemingly trial and error experimental approach by many private and governmental agencies. (p. 165)

The pointed observations and conclusions offered by Kunce were a reflection of the seemingly naive and ineffective approaches of many governmental agencies at the time. Unfortunately, such approaches were not subjected to a rigorous research methodology to identify the most effective elements of each program and retained for incorporation into future programs and strategies.

Counseling Strategies in the 60's

Kunce and Cope (1969) offered the following counseling strategies for working with the "culturally disadvantaged":

- "If counseling and psychotherapy are to be used with the disadvantaged, considerable modifications in theory and goals are needed..."
- "The counselor needs to understand the environment of the poor, to recognize and cope with unique kinds of hostility that the client may pose, to understand language differences, and to be sensitive to motivational differences..."
- "Individual counseling relationships are fraught with problems creating a need for para-counseling relationships. Constructive counseling relationships may be obtained through the use of carefully selected, indigenous personnel who are "natural" counselors..."
- "The need to go beyond the one-to-one counseling relationship is illustrated by the value of involving other family members. Group counseling at times also seems appropriate."
- "Agencies need to make themselves more easily available to clients. Available strategies include: placing the agency close to the population areas (e.g. in the ghetto themselves); using outreach workers; developing close liaison with other agencies; delegating selected responsibilities of the professional counselor to clerical staff and to indigenous para-professionals." (pp. viii-ix)

Viewpoint of the Disadvantaged in the 60's

Riessman (1967), Ayers (1967), the National Rehabilitation Association (Undated), Kreimer (Undated), Kunce and Cope (1969), and Kunce (1969) offered some very interesting, and often contradictory, views of people with disabilities who were labeled as "socially disadvantaged", "culturally disadvantaged", "disadvantaged", and the like. While the labels used to describe these persons were considered appropriate at the time, by today's standards they are viewed as offensive, stereotypic, and discriminatory. Yet, it is important to note that many of the recommendations are similar (exclusive of the labels) to those which have appeared in the rehabilitation literature in subsequent years. This suggests that the methods and procedures for more appropriately serving culturally diverse populations have been identified for over 25 years, but have not been effectively incorporated into the rehabilitation service delivery system.

Rehabilitation in the 1970s

A review of literature from the 1970s reveals little which documents service delivery to culturally diverse populations with disabilities. The existing rehabilitation literature on multi-cultural populations is accentuated by the contributions of the Rehabilitation Services Administration (1970); Chan (1976); Chimori, Hatanaka, Higashioka, Ishino, Sakamota, Uyekawa, Wakabayashi, and Chan (1974); Wakabayashi (1977); Ayers (1977); Rivera (1977); Stewart (1977); and Harper and Fisher (1979).

A Review of the Literature of the 70's

The literature, as reflected by the Vocational Rehabilitation Regulations Section 402.1 defined "disadvantaged" as:

> Disadvantaged individual means any individual disadvantaged in his ability to secure or maintain appropriate employment by reason of physical or mental disability, youth, advanced age, low education attainment, ethnic or cultural factors, prison or delinquency records, or any other condition, especially in association with poverty, which constitutes a barrier to such employment. (RSA, 1970)

It is important to note the elements which were prominent in this definition. Again, the literature reflects that "cultural factors" were considered as characteristics of the disadvantaged during the 1960s and were contributory factors to qualifying for the State-Federal VR system in the 1970s.

RSA (1970), in Vocational Rehabilitation of the Disabled Disadvantaged in a Rural Setting, noted that Black Americans constituted 58.7 percent of the population who did not migrate to metropolitan cities but remained in rural areas. Concurrently, Amos and Grambs (Cited in RSA, 1970) "...identified the characteristics of the migrant rural disadvantaged as having minority group status, poor and intermittent educational opportunities, generally low aspirations of parents, need to supplement family income, and isolation from normal community life and resources." They stated: "Today's victims of poverty live in a different world from yesterday's immigrant poor. They are nonbelievers, they are distrustful, they are victimized, and they know it" (p. 9). McPhee (Cited in RSA, 1970) indicated that, while the rate of unemployment was about 4 percent nationally, it ranged from 18 percent to 37 percent for the rural population. In a study of counselors' rankings of selected problems of rural disadvantaged populations, RSA (1970) found the following rank-ordering.

Rank Order	Problem
1	The nature of client's motivation
2	Inadequate economic opportunities
3	Client's educational-vocational deficiencies
4	Client's health-related problems...
5	Unavailability of needed medical, psychological, educational, and vocational facilities

6	Inadequate public transportation
7	Client's lack of financial resources
8	Lack of counseling "know-how" to work effectively with this particular group

These findings suggest that the problems for rural populations are multifaceted. However, it is interesting to note that a great deal of emphasis is placed on the deficiencies of the person with little on the counselor's "know-how" or the rehabilitation system.

Services for Asian-Americans

Chan (1976) suggested that a mistrust for all public service delivery systems has developed among Asian-Americans. This tends to discourage service delivery utilization by this population. Motivation and use of services can be achieved when appropriate considerations are taken. For example, Chimori, Hatanaka, Higashioka, Ishino, Sakamota, Uyekawa, Wakabayashi, and Chan (1974) found that "If the initial contact with Asian-Americans was within a community that contained elements familiar to the person such as bilingual literature, bilingual staff, and respect for cultural protocols, they were able to attract Asian-American users." (p. 3)

Wakabayashi (1977) indicated that the history and cultural values of Asian-Americans provide major barriers to service to persons with disabilities. Among them were cultural hesitation, family shame and disability, alternative institutions, community attitudes, community image and self image, and fear and mistrust by ethnic consumers. Solutions to these barriers include:

- Community education and community validation
- Reduction of ambiguity on eligibility requirements
- Bilingual literature and bilingual staffing
- Respect for culturally familiar protocols

Services for Black Americans

Ayers (1977) observed that the challenge of helping Black Americans with disabilities develop to their fullest potential is for society to undertake four basic activities:

1. Obtain accurate statistics on the incidence of disabling conditions among Black Americans.

2. Examine the present social and rehabilitation service delivery systems.

3. Develop a pool of manpower resources for social and rehabilitation services that can relate to Black Americans with disabilities.

4. Develop human relation programs and make them mandatory for all professionals in social and rehabilitation services to sensitize minority groups. (pp. 433-434)

Ayers (1977) further noted that the following were required to effectively serve Blacks:

1. Develop a sincere desire and commitment to help Black clients.

2. Develop in their agency a library of books, papers, and periodicals dealing with Black history and culture.

3. Learn and respect the language patterns of the Black client so that they can communicate adequately with him.

4. Help overcome the dehumanizing procedures of the present rehabilitation system.

5. Have dialogues with a wide variety of Black citizens.

6. Develop and participate in sensitivity training programs designed to deal with rehabilitation workers' attitudes toward Black people.

7. Develop and participate in in-service training programs designed to help them gain knowledge and understanding of the Black...

8. Start listening to what Black clients have to say about their needs, social and rehabilitation services

9. Become involved in community action projects and other community activities in the ghetto. (p. 436)

Services for Native Americans

Stewart (1977) identified two major problems which drastically limit the provision of rehabilitation services to Native Americans with disabilities: (a) comprehensive data on all disabling conditions do not exist, hence, the Indian Health Service does not keep statistics on the number of persons with conditions considered disabling, and (b) the tendency among many Native American communities to absorb the person with a disability, or other "different" person within the structure of the society.

Services for Hispanics

Rivera (1977) identified the following recommendations for consideration by the White House on Handicapped Individuals in order to effectively serve persons with disabilities with Spanish surnames:

1. ...the inclusion of the Spanish speaking community in all programs for persons with disabilities by the establishment of mechanisms that ensure meaningful input from them, and participation by them in those programs that affect them.

2. ...enforceable affirmative action programs that institutionalize the involvement of the Spanish speaking people at all levels of the organizational hierarchy of those programs and agencies that serve people with disabilities.

3. Provide for research and demonstration projects that explore effective means by which to serve Spanish speaking persons with disabilities in a manner utilizing the strengths of their culture.

4. Promote cultural awareness training that promotes understanding, acceptance and respect for all persons regardless of race and sex. (pp. 447-448)

Steinberg (1977) provided recommendations from a short-term training conference sponsored by RSA on "Cultural Factors in the Rehabilitation Process." Among the recommendations were:

- "Provision should be made at the national and regional levels for research and training to make available to counselors and service providers knowledge of cultural factors in the rehabilitation process."

- "Special project funds should be made available to demonstrate means of improving and expanding services to handicapped persons of subcultures and minorities."

- "Traditional curing systems and healing practices should be reinforced..."

- "...working with clients of another culture may take longer due to cultural, language communication, transportation, and other barriers should be considered in determining the length of time the client may remain in 'extended evaluation'."

- "Members of minority cultures often go back and forth between the culture of the majority and their own. Often they operate effectively in both cultures and these factors must be kept in mind when working with these groups." (pp. 153-155)

Harper and Fisher (1979) conducted research on the white counselor and nonwhite client in the vocational rehabilitation setting. Among their findings were:

1. Vocational rehabilitation counselors, regardless of race, should be familiar with the history, sociology, psychology, and economics of their nonwhite clients...

2. The vocational rehabilitation counselor must reach out to help the nonwhite client by using all available support and strategies for providing needed jobs, services, and resources to help the client to meet physical, psychological, social, and vocational needs.

3. The counselor should be a social model, teacher, and motivator. Moreover, the counselor should use directive, confrontive, persuasive, information-giving, supportive, and probing counseling techniques (i.e., primarily action-oriented techniques).

4. White counselors must be committed to helping the nonwhite client if their counseling is to make a difference...

5. There should be a more concerted effort by training programs and their personnel to examine their philosophies and policies conscientiously and to eliminate the policies and practices that perpetuate racial bias and prejudice among their faculty and students...

6. Training programs should commit themselves to developing realistic and effective policies, procedures, and practices for recruiting, selecting, retraining, training, and graduating nonwhite rehabilitation counselors... (p. 355)

As indicated by the literature rehabilitation experienced a significant change from the 1960s to the 1970s which reflected (a) enlightened awareness of cultural characteristics, (b) the need for more research, education and training, (c) recruitment of persons from multi-cultural backgrounds and (d) commitment to helping multi-cultural people with disabilities. However, multi-cultural professionals continued to strongly object to the quality and quantity of rehabilitation services provided by the State-Federal rehabilitation program for persons from minority cultural groups.

Rehabilitation in the 1980s

The era of the 1980s witnessed a major explosion in the rehabilitation literature as professionals began to visibly address the quality and quantity of rehabilitation services to people with disabilities from minority backgrounds. Atkins and Wright (1980) compared Blacks and Whites with disabilities who participated in the public VR program using closure data. Among their findings were:

- Blacks referred to VR were more likely than Whites to be financially impoverished and on welfare.
- Weekly earnings at referral were less for Blacks than for Whites.
- Compared to Whites, Black VR applicants were not only more likely to be screened out (found ineligible), but, if made eligible for services, Blacks were less likely to be rehabilitated.
- Blacks were less likely to be provided education and training.
- The percentage of Whites (11.29%) receiving higher education more than doubled that of Blacks (5.14%).
- Blacks received less costly VR services.

Humphreys and Provitt (1980), in a response to Atkins and Wright (1980), indicated that: "The data implications are serious and RSA is committed to follow-up investigative actions. More and specific investigations and examinations are needed to substantiate the data...Whether racial bias is operating in the vocational rehabilitation program can only be tested by further analyses..." (p. 41). Bolton and Cooper (1980), in a comment on the study by Atkins and Wright, were of the opinion that "...their arguments are sometimes misleading and that their interpretations are generally overstated and occasionally erroneous" (p. 41).

Findings similar to those of Atkins and Wright (1980) were identified by Ross and Biggi (1986). (For more information see National Council on the Handicapped, 1986; Walker, Belgrave, Banner & Nicholls, 1986; Walker, Belgrave, Nicholls, & Turner, 1991; Walker, Fowler, Nicholls, & Turner, 1988; & Wright, 1988.)

Johnson and Wen (1980) identified several recommendations from a Workshop at Jackson State University which addressed "Improving Nonwhite Participation in Rehabilitation Services for the 1980s." Among the issues addressed during the Workshop were recruitment, retention, and employment of nonwhite rehabilitation workers. Humphreys (1980), then Commissioner of Rehabilitation Services, in his closing remarks to the Workshop perhaps summed up the recommendations best. He noted:

> First, it is generally and widely acknowledged that the incidence of disability among blacks and other minorities in this country is twice that of the white population. This means rather than providing services to these populations that coincide with their percentages of the population nationwide, we should be increasing the level of service to twice that percentage...Second...If we are going to attract minority clients to that system and if we are going to get them the services they so desperately need, we need a much higher proportion of rehabilitation professionals, counselors, supervisors, and administrators who are Black, Hispanic, Asian, and Native American...Third...a major effort must be launched which will insure that greater emphasis is placed on meeting the needs of our minorities, both in the delivery of rehabilitation services and in training professionals to deliver, supervise , and administer those services. (pp. 35-36)

Similar, though not as detailed, recommendations were identified by Carney (1991), Commissioner of Rehabilitation Services in the National Training Needs Analysis and Summary-1990. (For additional information see: Atkins, 1986, 1988; National Institute of Handicapped Rehabilitation Research, 1984; Wright & Leung, in press.)

The Institute on Rehabilitation Issues (IRI)

Corthell (1981) convened an IRI study group whose purpose was to "Identify unique problems of service delivery to inner city nonwhite clients and suggest strategies for the amelioration of these unique problems" (p. iii). In addition, the group's charges were to: "Provide a statement of the problem from a historical perspective.; Discuss characteristics of the group as contrasted with the other rehabilitation client groups.; [and] Discuss administrative, supervisory and counselor issues and give recommendations" (p. iii).

The problems and characteristics were not unlike those in the information from the 1960s and 1970s as discussed above. However, one recommendation which appears to be a consensus was that: "...a concerted and continuous effort should be made to inform inner city nonwhite disabled residents of their rights, responsibilities, opportunities, and the procedures under the vocational rehabilitation program" (p. 93). Additionally, recommendations were offered for administrators, supervisors and counselors. For example:

Administrators. "Whenever legislation is enacted affecting the quality of life of individuals with disabilities, designated administrators should disseminate this information to community-based organizations serving the inner city neighborhoods" (p. 94).

Supervisors. "It is suggested that supervisors take the initiative to seek out and find community-based outposts in inner city neighborhoods to make services more accessible to minority groups with disabilities. The counselor should report to the outpost on a regular schedule, on the same day, and at the same time each week" (p. 94).

Counselors. Rehabilitation counselors should avail themselves of any and all training on the cultures of clients with whom they work. If not provided by the agency, counselors working with disabled nonwhite clients, should request additional education and training by professional nonwhite organizations" (p. 95).

When speaking of disability, Bowe (1983, 1985a, 1985b, 1985c, 1991a, 1991b, 1991c) provided perhaps the most comprehensive description of minorities with disabilities based upon data from the US Census Report. His most recent findings indicated that more than one-third of all severely disabled working Americans are minority group members.

Rehabilitation in the 1990s

As reflected in Workforce 2000 (Johnston and Packer, 1988) and One-Third of A Nation (American Council on Education, 1988), the workforce will grow older, more female, and more disadvantaged than at any other time in the history of the United States. These trends will raise a number of important policy issues. Johnston and Packer (1988) have noted that: "If the United States is to continue to prosper-if the year 2000 is to mark the end of the first American century--policymakers must find ways to (among others): "...Integrate Blacks and Hispanic Workers Fully into the Economy..."(p. xiv) Newman (Cited in American Council on Education, 1988) stated that: "We have made enormous progress over the last 30 years in dismantling barriers to the full participation of minorities in American life. But we have a long way to go before we can say that the American dream is everyone's dream." (p. v) He also indicated that some of the more difficult barriers to full participation by minority young people are so obvious, and a new understanding and a more creative approach to the barriers to success faced by minority youth is needed. Rhodes (Cited in American Council on Education, 1988), President of Cornell University and Chair of the Commission on Minority Participation in Education and American Life, also stated:

> After extensive examination of demographic and economic data, review of the relevant research in the field, and consultation with numerous experts, the Commission reached a disturbing conclusion: America is moving backward--not forward--in its efforts to achieve the full participation of minority citizens in the life and prosperity of the nation. (p. vii)

Corthell (1991) in the Eighteenth IRI noted that:

> Diversification of the work force will challenge rehabilitation to be proactive and appropriately responsive. Such challenges are not strangers to the rehabilitation community. Since its inception, rehabilitation has advocated for the rights of persons with disabilities. In many ways, difference is the standard in rehabilitation practice. The strength of rehabilitation's commitment will be tested as more diverse groups demand services." (p. 14)

The philosophy of rehabilitation in the 1990s may be accurately reflected in the following comments from the Eighteenth IRI (Corthell, 1991):

- All individuals, regardless of personal characteristics, have the right to equal opportunity. They should be guaranteed opportunities for active participation in the rehabilitation process. Their skills must be the determining factor rather than their personal characteristics.

- The right to independence reflects the need for diverse employees to assume greater responsibility and control over their own lives, to enjoy the privileges inherent in the rehabilitation work movement, and to share in the responsibilities of insuring the best work environment possible.

- All persons want and have the right to be respected as an individual. A major commitment in rehabilitation reflects the concern for the individual. Thus, the rehabilitation community is expected to welcome and advance full acceptance of the individual into the organization. (pp. 14-15)

The philosophy of rehabilitation toward multi-cultural individuals with disabilities in the 1990s must also be characterized as one which views diversity as valuable and important. This view represents a healthy psychological state which values the entire "human experience," including individuals of all ethnic groups, races, cultures, gender and class, and people with disabilities. It is also important to the future health and well-being of rehabilitation professionals to acquire more knowledge and skills in order to serve these populations more effectively. While these conclusions and recommendations are not new, rehabilitation must rededicate itself to achieving this mission. It must also bear in mind the opinions and conclusions reached by Johnston and Packer (1988), Newman (Cited in American Council on Education, (1988), and Rhodes (Cited in American Council on Education (1988).

In order to achieve the goals of the ADA, the federal and state governments and the state-federal VR program must incorporate into their knowledge, values, service delivery practices, and philosophy, a greater understanding of the characteristics and concepts which underlie effective service delivery to multi-cultural persons with disabilities. Among them are culture, race, ethnicity, multiculturalism, cultural pluralism, assimilation/acculturation, melting pot myth, Eurocentric orientation, Africentric orientation, and ethnocentrism.

Implications and Conclusions

This chapter has highlighted the progression of the issues of Cultural Diversity in Rehabilitation. Society and rehabilitation have slowly progressed from the opinion that people with disabilities from different cultures have a double disability to one of recognizing their assets. In order to capitalize on these views, it is important for the future of rehabilitation that professionals acquire the knowledge and skills to serve individuals from culturally diversified backgrounds.

Chapter Four

Culturally Responsive Rehabilitation Services

Culturally Responsive Rehabilitation Services

Objectives

1. To identify the need of rehabilitation to become a more culturally responsive organization
2. To define a culturally responsive, culturally competent, and culturally appropriate rehabilitation delivery system
3. To identify the principles, strategies, and practices which operationally define a culturally responsive organization
4. To understand the organizational implications in service delivery, staffing, and diversity management to achieve cultural responsiveness

Summary

The building of a culturally responsive service delivery system simply means making sure that VR works equally well for all the populations it serves. VR is presently facing a dilemma in that services to the majority culture overall have been beneficial, while services to minorities have not been that successful. The need to increase VR's effectiveness with culturally distinct populations is driven by two factors: the evidence that rehabilitation has historically been less effective in outreach, service, and outcomes with African Americans, Asian Americans, Pacific Islanders, Hispanics, Native Americans, and other culturally diverse groups; and a recognition that such populations will make up an increasingly larger percentage of those in need of rehabilitation services.

Related phenomena are the structural changes in the global economy, and the advances in technology, telecommunications, and transportation which make traditional boundaries of nations less significant. Thus, the need to understand and interact with persons whose dominant culture is different from the majority culture. The changing demographics of the workforce also has critical implications for the staffing of rehabilitation agencies and the management of cultural diversity.

Discussion

The following story by Sue (1992) illustrates the dilemma facing rehabilitation agencies today:

> Several years ago, I heard an interesting tale from a Nigerian counselor who was attending one of my multicultural counseling workshops. The tale, often told to Nigerian children, goes something like this . . . . .
>
> A white female elementary school teacher in the United States posed a math problem to her class one day. "Suppose there are four blackbirds sitting in a tree. You take a slingshot and shoot one of them. How many are left?" A white student answered quickly, "That's easy. One subtracted from four is three." An African immigrant youth then answered with equal confidence, "Zero." The teacher chuckled at the latter response and stated that the first student was right and that, perhaps, the second student

should study more math. From that day forth, the African student seemed to withdraw from class activities and seldom spoke to other students or the teacher.

This story gets to the heart of some fundamental issues confronting the multicultural movement in the United States. If the teacher had pursued the African student's reasons for arriving at the answer zero, she might have heard the following: "If you shoot one bird, the others will fly away." Nigerian educators often use this story to illustrate differences in world views between United States and African cultures. The Nigerians contend that the group is more important than the individual, that survival of all depends on interrelationships among the parts, and that individualism should be de-emphasized for the good of the whole. The fact that the white child arrived at a different answer may suggest world view or belief that the psychosocial unit of operation is the individual, that rugged individualism should be valued, and that autonomy of the parts and independence of action are more significant than group conformance." (pp. 7-8)

The Need and Scope

The need to address quality, equity, and efficiency of rehabilitation services provides the primary impetus for moving toward cultural diversity in rehabilitation. This movement reflects basic values in the rehabilitation service delivery system, and follows the rehabilitation tradition for leadership and innovation, coupled with the need to expand the base of supporters and to position VR for the future. Quality, equity, and efficiency are defined and discussed below.

Quality means rehabilitation practices are attuned to the needs of the client group being served. Quality is defined by the cultural subgroup receiving services, through measures of customer (client) satisfaction. An emphasis on excellence and a de-emphasis on numbers has refocused service quality as an important VR value.

Equity as a goal to assure that all of the populations served by VR have an equal opportunity to receive and benefit from services. The drive to achieve equity is based on traditional rehabilitation values of fairness and steered by culturally appropriate approaches. The attainment of equity may require strategies that are unequal in approach. "It is ironic that, in counseling, equal treatment may be discriminatory treatment. And differential treatment is not necessarily preferential" (Sue, 1992).

Efficiency is achieved when the right approach is used with the right population and brings the right results. Traditional outreach strategies were designed for the majority but used for African-American, Hispanic, Asian-American, and Native American communities. Service delivery strategies, which result in underserved populations and/or "unsuccessful closures" represent a poor return on investment for rehabilitation.

As the recipients of rehabilitation services change, it becomes important to gain support for the rehabilitation program from the emerging base of people who represent culturally diverse groups. The ability of rehabilitation to survive in the 90's will depend on satisfying its customers, and the willingness of those representing culturally diverse populations to advocate for the state/federal rehabilitation program. Marketing experience indicates that satisfied customers are the most effective "advertisers" for the product. High quality, culturally responsive services will expand the number of supporters for vocational rehabilitation. Conversely, a large number of dissatisfied or unserved customers will place the rehabilitation program in an untenable and risky position.

From an organizational development perspective, the emerging challenge for VR is to integrate new members into its workforce, and build on the cultural strengths of these new members. The need is to assure that VR manages its diversity by becoming what Adler (1986) defines as a synergistic organization--one which recognizes that a combination of various (culturally-based) approaches is best. A synergy is created by weaving the cultural threads--the strengths, values, and attributes of diverse cultural groups--into a new whole cloth. Adler also suggests that "diversity becomes an advantage in starting a new project, creating a new idea, developing a new marketing plan, planning a new operation, or assessing trends from a new perspective. . . . Overall, the advantages of diversity include enhanced creativity, flexibility, and problem-solving skills" (pg. 14).

A Culturally Responsive Organization Defined

A culturally responsive VR organization is operationally defined as:

> An organization which understands the needs, assets, and values of the various cultural groups it serves, and is able to apply that knowledge which assures that appropriate strategies are applied to achieve equity and quality of services.

A responsive rehabilitation organization is driven, not by the traditional VR "product" it has to offer, but rather by the assessed needs of the given market segment (cultural subgroup) it is attempting to serve. An effective culturally responsive organization is measured by how well it satisfies its customers and is able to achieve equity in client services and outcomes for all of the culturally distinct populations it serves.

Creating a culturally responsive organization is essentially an organization development (OD) initiative--changes must occur in human resources, systems, technology, policies, practices, and in the organization's culture. The change process should be geared to achieve Cox's (1992) definition of a multicultural organization "as one where, among other things, status and opportunity to contribute are unrelated to group identity, and where the unique cultural heritage of minorities is valued and preserved rather than denied and excluded." (p. 2) It is important for rehabilitation professionals to understand that the achievement of this organizational status is strongly interwoven with the ability to effectively serve an increasingly culturally diverse client population. Training, team building, and other efforts must address the need for change in three essential dimensions--attitude, knowledge, and skills--necessary to create a culturally competent organization. The organizational development process will be geared to concurrently addressing enhancement of the service delivery system and the management of workforce diversity. The approach is long term, comprehensive and systematic; intended to effect a real change in the way the VR agency does business. For VR, the approach to change is both strategic and market-driven. It is keyed to the strengths that rehabilitation brings--in technology, systems, values, policies, and practice--which must be linked to the real needs of its consumers: African-Americans, Hispanics, Native Americans, Pacific Islanders, Asian Americans, and other culturally diverse populations.

Becoming a Culturally Responsive Organization

A culturally responsive organization can be defined by its practices, principles, and value orientation. According to M. K. Ho (1987) the following attributes and principles characterize a rehabilitation system which is able to effectively serve culturally diverse populations.

Table IV-1. Cultural Value Preferences of Middle-class White Americans and Ethnic Minorities: A Comparative Summary

Area of Relationship	Middle-class White American	Asian American	American Indian	Black American	Hispanic American
People to Nature/ Environment	Mastery Over	Harmony With	Harmony With	Harmony With	Harmony With
Time Orientation	Future	Past-present	Present	Present	Past-present
People Relations	Individual	Collateral	Collateral	Collateral	Collateral
Preferred Mode of Activity	Doing	Doing	Being-in-Becoming	Doing	Being-in-Becoming
Nature of Man	Good & Bad	Good	Good	Good & Bad	Good

Individually Based Services

The rehabilitation service delivery system is linked to the needs of the individual, which are in turn, shaped by that person's cultural values, beliefs, and behaviors. Building services based on the needs of the individual is a strength of the VR program; recognizing that individual needs occur in a cultural context is fundamental to building a system which better serves culturally distinct populations.

It is useful if one recognizes that significant differences also exist among individuals of the same culture--due to a wide variety of factors. Cultural stereotyping is dangerous and can be avoided if the service providers acknowledge culture as one of several significant variables in building a customer-responsive program. Within the same culture, differences among individuals also exist in terms of geography, age, degree of assimilation, individual personality, and the extent of "cultural/racial identity" (Sue, 1990).

The values and behaviors of individuals within a minority culture will be shaped by the extent to which they accept (and identify with) their own culture as well as the majority culture. As an example, a Native American from the Potawatomi Tribe living in an urban area may have values similar to the majority culture rather than those of an individual who resides in a reservation community where historical Potawatomi tribal values are kept intact. A Mexican-American who is rejecting this "identity" may adopt an assertive individualistic style which is atypical to this culture. The natural and extended family support may be less significant to an African-American who has had to relocate from his/her original roots. A member of the expanded African-American community, however, may serve in the role of significant other and "family" to the individual.

The implications for rehabilitation of the issues discussed above are threefold. First, culture will shape behavior and values and help define what is perceived as appropriate or inappropriate for culturally diverse populations; second, cultural misconceptions or cultural stereotypes are both failures to recognize the role of culture and its unique interaction with the individual. Watson (1988) has described the negative impacts of counselor cultural encapsulation (lack of information about cultures different from one's own, and insensitivity to the impact of diverse cultures or the client's feelings and behavior) which, among other issues, results in counselor-client misunderstandings of verbal and non-verbal messages. Third, the rehabilitation service delivery system is a product of the dominant culture which may be inherently unfriendly to those whose cultural orientation differs.

Organizational Implications

The VR agency should be an organization which values diversity and emphasizes that value in its mission, policy, principles, procedures, and practices. It is critical that organizational leaders demonstrate a commitment to this value in theory and practices which guide agency activity. The integration of this value into the organization is not a "quick fix" process achieved by brief training programs. Katz and Miller (1988) view the transition from a monocultural organization to a multicultural one as a "long-term total effort . . . [which involves] changing the entire fabric of the organization [and means] creating a new organizational culture in which diversity is seen as adding value to the organization." (p. 2).

The Michigan Rehabilitation Services has developed the following statement to express it's belief and commitment.

> We envision Michigan Rehabilitation Services as an organization that demonstrates its value for diversity among staff and customers by: (1) creating and sustaining an environment which encourages and supports diversity in staffing, viewpoints and perspectives; (2) developing and supporting a service delivery system which ensures equitable and appropriate outcomes for all customers; and (3) advocating and modeling the principles of diversity in all policies, procedures and practices. (McConnell, MRS Paper, 1992.)

This value may appropriately be translated into goals, objectives, workplans, policies, and procedures which serve to operationalize the value. The stated value will serve as a stimulus for three of VR's cultural diversity elements--diversity management, agency staffing, and client service delivery. The diversity management component is directed at maximizing the effectiveness of a diverse workforce by assuring inclusiveness in all organizational aspects by all agency members. It builds on the strengths of diversity by facilitating acceptance, communication, understanding, and collaboration across cultures.

Staffing goals are directed at assuring a workforce which, at a minimum, is representative of the population eligible for services, and which assures cultural diversity at all levels within all units of the organization. The agency must incorporate activities for both recruitment and retention to support the diversity staffing goal. The Washington State DVR agency has established a goal "to improve the ability of DVR to successfully employ and retain ethnic minorities and other protected group members." (Washington DVR, p. 21). Within this goal, the agency has established specific representation targets for administration, supervision, professional, and office/clerical classifications.

Service equity and service quality are reinforced by the agency's activities in the other two domains of diversity, staffing and management. An organization which purports to have made a commitment to quality services to culturally diverse populations will be measured on its own performance in staffing and retention of minority group members.

The culturally responsive organization assures that its staffing pattern reflects its diversity value and the populations it serves. Achievement of this principle requires the establishment and maintenance of three important staffing subsystems: recruitment, retention, and workforce diversity management. Strategies which work to obtain and retain bi-cultural staff are put in place in order to reap the qualitative benefits of workforce diversity. Bi-cultural staff (i.e., persons who function effectively in more than one culture) can have a major impact on VR service delivery approaches as they are able to translate and transcend the "system." A word of caution is in order. The agency should not assign all of its staff to serve only clients of the same culture, nor assume that culturally diverse clients will automatically be better served by staff of the same culture. Culturally diverse clients will be better served by quality professionals who are culturally competent. The value of recruiting and selecting bi-cultural staff in clerical and administrative support functions should not be overlooked. Such staff should not be viewed as substitutes for bi-cultural counselors, but should be considered as a key element of an overall diversity staffing pattern and an effective tool in bridging the VR agency and the community. An African-American secretary, for example, may have excellent knowledge of the Black community, its leaders and resources, and enjoy a high level of respect and power in that community. An African-American client may feel more comfortable asking questions or sizing up the VR program based on her information. The value of staff who are representative of the population served includes: (a) credibility in the eyes of culturally diverse segments; (b) familiarity and understanding of the culture of the client, and (c) diversity of perspectives which can improve overall service quality.

Operationally, the organization must manage this staffing initiative through:

- targeted recruitment plans which are driven by a larger organizational plan for assuring workforce diversity;
- stated goals and accountability mechanisms for managers on recruitment, retention, and diversity management;
- demographic data on the state's population mix by geographic catchment area;
- specific plans which are responsive to retention and diversity management issues;
- programs which recognize, reinforce, and celebrate the strengths, values, and contributions of various cultures; [and]

- efforts which distinguish the new diversity approach from the traditional affirmative action approach. The management of diversity must be treated as an essential skill in order to maximize the agency's human resources and increase the organization's effectiveness. (McConnell, 1992)

Thomas (1988) makes the following comparison of the traditional Affirmative Action approach to that of managing diversity:

Table IV-2. Affirmative Action--Managing Diversity: A Comparative Analysis

Affirmative Action	Managing Diversity
Tends to focus sequentially on groups	Simultaneously focuses on needs of all groups
Does assume that members of "protected" groups have deficits	Assumes members of all groups have potential
Flows from social responsibility, moral, and legal motives	Priority given to motives related to competitive business posture
Grounded in assimilation, melting pot vision	Grounded in "multicultural" vision
Recognizes that people who are different may have special needs	Recognizes that people who are different may have special needs and also that their managers may have special needs
Focuses on minorities and women	Includes white males in definition of diversity and focuses on racial, sexual, and other forms of diversity
Does not emphasize system and cultural changes, but stresses adaptation by those who are different	Stresses changes by individual and also within organizational systems and cultures
Places heavy emphasis on program intervention	Stresses the need for multi-interventions: • training • cultural changes (cultural audit) • system changes (system audit)
Does not stress importance of diagnostic data	Stresses importance of data-based interventions
Builds on measurement by the numbers	Utilizes measurement by the numbers plus other indices
Is often reactive Does not require mindset change	Is proactive, based on diagnosis. Requires mindset changes: • management • leadership • managing diversity

(Thomas, 1988, unpaged paper)

Service Delivery Applications

An organization will need to use policies in innovative and flexible ways to achieve quality, culturally appropriate services. Policies and past practices may have a negative impact on service provisions if they are contrary to cultural values, norms, and beliefs. Examination of existing policies and procedures must assure that programs are "user friendly" to the particular population being served. An assessment of policies by members of the population being served (market segment) will help to assure that policies are culturally responsive. Further assessment should assure that agency policies do not reinforce the traditional distrust minority populations have of human service systems. For example, intake policies which appear to be equal may actually operate as deterrents. An intake policy which requires certain information may discriminate against some client groups which have unequal access to that information. Waiting list or deferred intake practices may serve as a de-facto denial of service to certain ethnic populations who either cannot afford to wait or perceive the waiting list as another ploy to avoid provision of services. It has been suggested that so-called free services can actually impose a real cost on clients (Prottas, 1981) in terms of time, resources, distance, etc.

The effective culturally responsive agency promotes understanding and appreciation of the uniqueness of various cultures. Traditionally, minority populations have been viewed in a deficit context (i.e., lacking the values, attributes, or qualities of the dominant culture). This deficit orientation, evidenced in terminology like "culturally deprived", "disadvantaged", or "underprivileged", creates several problems in perceptional orientation. First, it denies that other cultures have their own unique integrity; second, it affixes the problem within the "disadvantaged" client. On the other hand, a culturally-linked approach enables the service provider to build on the strengths of the individual's culture and use the unique resources of that culture to effect solutions. Atkins (1988), in addressing needed changes in serving African-Americans, describes this as an asset-oriented approach. A different perception set is created which enables VR service providers to expand their focus from client-based problems to systemic barriers which may impede success.

Significant investment must be made by service providers to understand the attributes of a culture through training, reading, and involvement in the community. Green (1982) identifies the "acknowledgment of cultural integrity" as one of the five keys to attaining ethnic competence. For the rehabilitation practitioner, the intent is to move toward a state of multiculturalism: "an ideal state of an ongoing process where a person is able to feel comfortable in and communicate effectively with people from many cultures and in many situations. Identities, self concepts, outlooks, and value formations transcend cultural considerations and make VR very open to new experiences." (Hoopes, 1979, unpaged handout.)

A culturally responsive organization designs and evaluates its programs and services based on the needs, interest, and input of the specific cultural groups it is serving. In marketing terminology, services must be targeted to a specific market segment to be most effective and result in customer satisfaction. If, for example, VR is to expand its services to the Saginaw Chippewa Indian Tribe in Michigan, it must first identify and study their needs and get specific feedback from members of that community on how to measure client satisfaction. In this example, the use of small focus groups of Saginaw Chippewa Indians may be useful in both planning the needs assessment and designing program satisfaction instruments. The focus group strategy here (the use of a homogeneous group to define an issue/need for further exploration) might be linked to the tribal culture. As an example, using the Elders[1] or the Tribal Council of the Saginaw Chippewa Nation to select or to serve as members of the focus group. Targeting services to validated client needs avoids providing services based on assumptions about clients in general or stereotypes about the group. The method for gathering data is as important as assessment of the data because responses will be culturally influenced. The fact that minority populations have historically been studied and restudied without evidence of much benefit makes the need assessment more difficult. More importantly, it dictates that the information obtained from the "customer segment" be used to address the identified needs.

Rehabilitation must develop partnerships with service consumers, their advocates, and service providers who are a part of the particular culturally diverse community. Serving culturally distinct populations requires knowledge of the resources, service providers, and other important stakeholders in the community. Further, it requires forging new partnerships among many of these entities. The intent must be to build trust, understanding, and credibility among the support systems in the community. As an example the Washington State DVR (1990) agency has a comprehensive Minority Subplan with one of its goals "to strengthen the working relationship between DVR and both ethnic Minorities Communities and other protected group members" (p. 26). The goal includes separate action plans for both state level minority commissions and local community organizations.

Efforts must be made to understand the community, identify its important stakeholders, and establish relationships which facilitate communication, coordination, and collaboration. Rehabilitation must become more involved with the community and provide mechanisms--referent groups, advisory groups, forums, focus groups--which facilitate community involvement with VR.

A culturally responsive organization defines service quality in part by assuring equity in access, services, and outcomes for all populations. To achieve this standard, the organization must collect and maintain data, and monitor and evaluate performance against an established criteria, including client satisfaction. Adoption of this principle recognizes that excellence without equity does not exist. The focus of agency efforts must be on a "continuous improvement" model to achieve high levels of customer satisfaction with all cultural segments. Operationally, plans and strategies are put in place which should result in enhanced program quality and measured equity. The Michigan agency, for example, has identified a series of equity and evaluation questions for minority client populations which are linked to the four stages: intake, eligibility, plans, and the rehabilitation process. The evaluation questions drive the kinds of measures to be used and dictate the data to be collected. At intake, a question might be "are new applications for Mexican-American clients equal to their representation in the population catchment area?" Or, "Is the failure-to-return rate, after initial application, the same or higher for African-Americans as for other client populations?" Answers to these questions will help determine whether a problem exists in the service delivery system which may require further examination, and may also suggest a possible solution to the problem.

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[1] Elders in the Native American culture refers to a specific age group of a community and means those who are wise. Within the culture, the Elders are respected for their wisdom and must be deferred to by other members of the tribe.

Cultural Competence

The culturally responsive organization provides ongoing growth and development opportunities, and prepares staff at all levels to provide culturally responsive services. The goal for the organization is to achieve a level of competence to effectively serve culturally diverse clients. For the counselor, it means achievement of multicultural counseling competencies in the three critical domains--skills, knowledge, and attitude. Watson (1988) has identified 20 multicultural counseling competencies surrounding these three domains. Achievement of this status requires an understanding of other cultures, an awareness of the assumptions underlying traditional counseling theory, a level of self-awareness, and ability to translate that knowledge into culturally appropriate strategies. The rehabilitation manager must also develop cultural competence in these three domains, but the application is different. The manager uses that competency to build effective community networks, eliminate systemic barriers to success, and provide supports to the counselor. Support staff must also acquire a level of cultural awareness (and awareness of one's own perceptions) including a knowledge of customs, behaviors, values, and the results of racism. The culturally competent support person is able to translate this knowledge into telephone behavior, receptionist practices, and client interactions which build trust, establish credibility, and help create a culture--friendly environment for the African-American, Asian-American, Hispanic and Native American person with a disability.

Dana, Behn, and Gonwa (1992) have proposed an assessment checklist to determine the cultural competence of social service agencies. The checklist identifies some 34 factors in the categories of practices (staff, policy/attitudes), services, culture-specific services, community relationship, training, and evaluation in order for an organization to achieve cultural competence. Their definition of cultural competence "includes an ability to provide services that are perceived as legitimate for problems experienced by culturally diverse persons--cultural competence may be demonstrated at practitioner, consumer, agency administration, and policy-making levels" (p. 221).

It is necessary for both the counselor and manager to acknowledge the assumptions and practices which are inherent in the traditional service provider's program in order to move to the new multicultural model. A comparison of the traditional approach to the multicultural approach is depicted in the following chart developed by McConnell (1992).

A COMPARISON OF TRADITIONAL AND MULTICULTURAL PARADIGMS FOR COUNSELING AND SERVICE DELIVERY

Traditional		Multicultural
Client problem	versus	System barriers
Disadvantaged, deprived	versus	Culturally distinct
Cultural deficits	versus	Cultural strengths
Differences are bad	versus	Individual differences are value neutral, collective differences add value
Counselors as listener/advisor, coordinator	versus	Counselor as doer, activist and change agent
Same and equal treatment	versus	Different and appropriate

Riddle recognizes a growth continuum in attitudes towards differences from one of repulsion, where ethnocentrism is the orientation, to that of nurturance, where one assumes that differences in people are indispensable in society. For the rehabilitation community, *positive attitudes towards* differences should be the norm. Those attitudes can be manifested in behaviors of support, where rehabilitation works to safeguard the rights of those who are different, of admiration, where one acknowledges that being different requires strength; of appreciation, where diversity is valued; of nurturance, where one becomes an advocate for differences (Riddle, 1987, unpaged handout).

The activist role of the multicultural counselor is articulated by Lee and Richardson (1991). They suggest that counselors become "systemic change agents, channeling energy and skill into helping clients from diverse backgrounds break down institutional and social barriers to full development" (p. 4). This activist role of the counselor (and other rehabilitation professionals) is, in part, a recognition that the source of the problem resides more in restrictive environmental and social forces than with the client.

Green (1982) describes the characteristics of ethnic cultural competence as:

1. Awareness of one's own cultural limitation
2. Openness to cultural differences
3. Client-oriented, systematic learning style
4. Utilizing cultural resources
5. Acknowledging cultural integrity

Rehabilitation agencies must put in place a systematic human resource development plan which is linked to an organizational development plan in order to achieve cultural competence throughout the organization. A set of functionally linked cultural competencies should be developed for administrators, support staff, counselors, and managers. VR should involve other providers in the rehabilitation community in staff development efforts. (Training is discussed in more detail in a later chapter.) The plan should be driven by the organization's value orientation and should encourage and promote formal and informal avenues for growth and development as well as an appreciation of various cultures. For example, speakers, programs, and activities which focus on a given cultural group can be informative and interesting ways to educate organization members about the history, values, and contributions of a given culture.

A culturally responsive organization provides leadership in establishing a culturally responsive service delivery system. Both internal and external examinations must occur to identify and eliminate systemic barriers to the success of culturally diverse clients. Internally, this examination is targeted at policies, practices, procedures, and organizational factors which do not benefit certain groups. Externally, VR must identify resource gaps, attitudinal barriers, knowledge deficits, and systemic factors in the community which impede the success of culturally diverse persons with disabilities. The dependence of VR on other service providers and support systems may require that it educate, advocate, stimulate and/or develop community resources which will complement the capacity of VR.

Implications and Conclusions

Culturally Responsive Strategies

Some of the principles discussed in this chapter are highlighted in the following list:

1. Identify and build on cultural strengths.
2. Develop an understanding of the community--its norms, values, leaders, and resources.
3. Make use of resources and institutions unique to a given culture.
4. Be aware of your own values, assumptions, and stereotypes and make sure you are open to challenge.
5. Develop cultural competence in attitudes, knowledge, and skills.
6. Take services to the community.
7. Develop and use multicultural practitioners.
8. Focus on building trust.
9. Promote, promise, and practice culturally responsive services.

Questions for the Reader

1. Do existing policies and practices work equally well with the various cultural groups served? Is there evidence that some groups are disadvantaged?
2. Is the population mix in the community represented on the caseloads?
3. Are different outreach strategies used for different groups? How effective are they?
4. How well is VR known to the various segments in the community? What is its image among those various segments?
5. Does the agency communicate--in behavior, policy, practices--a valuing of cultural differences?
6. Do staffing patterns reflect the diversity value and population mix in the community?
7. Do methods exist to systematically assess needs and determine customer satisfaction in the minority community?
8. Are there data to measure performance with culturally diverse populations? How is it monitored? What does it indicate?
9. Are staff culturally competent? Is there a process to develop/maintain cultural competence for new and existing staff?

10. Is the agency defensive about its present services to culturally diverse populations, or proactive in striving for equity and quality?

11. How are the agency's commitment and values regarding cultural diversity reflected in its mission, philosophy, and goals?

12. Is a clear leadership commitment to cultural diversity reflected in words, actions, and modeling behavior?

13. Do members of the organization speak out against discrimination, racism, and injustices toward minority persons with disabilities?

14. Are the key service providers in the community (i.e., facilities, CIL's, training providers, psychologists) equally effective in serving culturally diverse populations? What are the agencies' expectations of them? How are they helped to improve?

15. Does race shape your expectations of clients?

Chapter Five

Methods and Strategies for the Provision of Services

Methods and Strategies for the Provision of Services

Objectives

1. To provide a frame of reference for examining methods and strategies for improving services to persons with severe disabilities from culturally diverse backgrounds

2. To review the professional literature relevant to methods and strategies

3. To present a sample of case material which reflects the current state-of-the-art for providing services to persons with disabilities

Summary

The handicapping conditions confronted by people with disabilities as they pursue independent living and career development are constructed by our social systems. A social system model of service delivery sees the individual as a system within progressively more encompassing systems: the family, peer group, workplace, and community. Previous chapters suggest that individual advocacy, professional support, peer support, organizational, and community strategies are needed to achieve successful rehabilitation outcomes, including the full integration of persons with severe disabilities from culturally diverse backgrounds, into their chosen communities. There is a need for a systemic approach to enhance the professional and cultural competence of service providers, managers of service providers and community leaders including representatives of groups of persons with disabilities. Such an approach is consistent with the current Human Resource Development (HRD) and Human Resource Management (HRM) initiatives of the Rehabilitation Service Administration (Pacinelli & Stude, 1992). Cultural competence is not something that can simply be added onto personal and professional competence. Cultural competence is acquired through a developmental process and is integrated with other aspects of personal development. A social systems perspective integrates these activities in a community model to achieve improved independent living and employment outcomes for persons with severe disabilities, especially of culturally diverse backgrounds.

A community model should focus attention on how deep and how wide is the cultural mainstream (i.e., promotes cultural pluralism in the community and diversity in the workplace). Price Wright's (1988) basic philosophical tenets for rehabilitation, argued that the focus in an integrated environment should not be directed toward elimination of all deviance, but rather on increased tolerance and support for those who may exhibit atypical appearance or behavior. The community model also addresses the perception of many consumers that rehabilitation professionals tend to look only within the person for disability-related problems or solutions. The community must sometimes be seen as the "patient", rather than the individual with a disability. It is at the community level that cultural differences may be understood and integrated into the whole.

Discussion

Vocational Evaluation, Eligibility Determination and Outreach

People from backgrounds other than the cultural mainstream (dominant culture) are underserved by the present disability service delivery system--both in terms of percent of eligible persons served and quality of outcomes (Walker, Belgrave, Nicholls, & Turner, 1991; Alston & Mngadi, 1992). Improving cultural competencies throughout the service delivery system offers one of the most promising strategies for responding to previously underserved populations. This is particularly true for that part of the rehabilitation process focusing on evaluation and eligibility determination.

Consumers of rehabilitation services and their advocates have often seen the vocational evaluation process as a gate keeping function which tended to exclude people in need of services, i.e., those with the most severe disabilities and those from culturally diverse backgrounds (Alston & Mngadi, 1992). The 1993 Amendments to the Rehabilitation Act strengthen the program outreach to both the most severely disabled and to members of racial and ethnic minority groups. The principles of presumptive eligibility, disability rights, and essential community services will remove many barriers to services for these groups.

The practice of recruiting minority group members into the rehabilitation profession and the general initiative to make the entire system more empowering to consumers will further remove barriers and provide opportunities for previously underserved groups.

The process of vocational evaluation, eligibility determination, and plan development calls for a partnership between the review provider and service consumer. A process of mutual consultation allows both to work from the other's perspective as well as their own. Akridge and Farley (in press) describes how making an assessment technology more user-friendly, client centered, and empowering goes a long way toward addressing the special needs of people with severe disabilities from culturally diverse backgrounds.

Cross-cultural Counseling

Pedersen (1990) challenges service providers with the following statement:

> In order to escape from what Wrenn (1985) calls cultural encapsulation, counselors need to challenge the cultural bias of their own untested criteria. To leave our assumptions untested or, worse yet, to be unaware of our culturally learned assumptions is not consistent with the standards of good and appropriate counseling. (p. 553)

The specialty area in human services that has remained most focused on the interaction of the helping professions with cultural issues is cross-cultural counseling (Heath, Neimeyer, & Pedersen, 1988; Pedersen, 1985; Crystal & Alston, 1991). Reviewing this body of literature can increase one's cultural awareness and opens up for exploration a number of interesting themes of inquiry. The present state-of-the-art, however, cannot guarantee results. The generic field of counseling still has many unresolved issues relative to the helping process. The area of cross-cultural counseling is even more complex and fraught with unanswered questions.

Rehabilitation service providers can, however, make use of a variety of resources including consultants with expertise in program development, program evaluation, and cross-cultural communication.

Stimulated by consumerism and the disability rights movements, rehabilitation professionals are showing more awareness of cultural diversity and the need for research. During the late 1970s and throughout the 1980s, combinations of psychosocial and lifeskills interventions were developed and tested. However, these programs demonstrated limited success, and the lack of generalization and maintenance of skill gains has been criticized. This lack of progress has been more pronounced in groups with the most severe disabilities and those most different from the cultural mainstream. Greater cross-cultural counseling competency is required if services are to improve.

Pedersen (1990), a recognized leader in cross-cultural counseling, proposed 10 counseling principles that promote cultural competence in helping relationships. These are shown in Table V-1.

Table V-1. Pedersen's Principles With Added Explanatory Comments

1.	The ability to see positive implications in an otherwise negative experience from the client's cultural viewpoint	Reframe, confirm
2.	The ability to anticipate potential negative implications from an otherwise positive experience provides multiple perspectives.	Employ multiple perspectives
3.	The ability to articulate statements of meaning helps to interpret or integrate positive and negative events in a constructive way without requiring the client to resolve the dissonance in favor of one or another culture.	Help construe experience in adaptive ways
4.	The ability to avoid simple solutions to complex problems and acknowledge the complicated constraints of a client's cultural context	Demonstrate cognitive complexity and tolerance for ambiguity
5.	Sensitivity to how collective forces influence an individual's behavior increases alternative interpretations.	Demonstrate understanding in relation to the individual's primary and secondary groups

6.	Sensitivity to the changing power of the person being interviewed over time is a result of counseling.	Empathy, warmth, respect, and planning elicit constructive assertiveness and empowerment.
7.	Sensitivity to the changing power of the person being interviewed across different topical areas reduces stereotyping.	Avoid focusing on barriers or deficits which contribute to helplessness. Allow and facilitate client to identify interest, expertise from his or her cultural frame of reference.
8.	Sensitivity to the changing power of the person being interviewed in culturally different social roles is essential to understand change.	Unconditional positive regard, appreciation of diversity, cultural awareness
9.	The ability to adjust the amount of influence by the interviewer can facilitate the independent growth of the other person.	Fading from intense stimulating exploration and coaching to serving as a resource person or consultant
10.	The ability to maintain harmony within the interview demonstrates a culturally inclusive perspective.	Rapport, intense relationship building

The knowledge and skills associated with cultural awareness and cultural competence are essential in all counseling relationships whether or not the counselor and client are from different cultural groups. A continued (and increased) emphasis on the professional development of service providers--including basic counseling skills training and supervision; and how to apply basic counseling skills in culturally diverse settings--is needed to improve the cultural competence of service providers and of agencies. A diversity orientation must be fused into program development and program evaluation. Quality assurance teams, including experts on program development, program evaluation, and multicultural communication, should be employed in every agency.

Working With Families

Family life is particularly important to many persons from minority cultures. Hosack and Malkmus (1992) describe the importance of family inclusion in vocational rehabilitation planning, assessment, and evaluation; and encourage the implementation of a "Family Service Plan." McDonnell, Hardman, and Hightower (1989) state that families have a significant impact on their members' opportunities for success in community employment. In fact, parent input may be viewed as one of the most critical quality indicators of a successful transition program (Sale, Metzler, Everson, & Moon, 1991; Schultz, 1986). Other authors (Turnbull & Turnbull, 1990; Turnbull, Summers, & Brotherson, 1984) have written in support of a family-systems approach to assessment and intervention for individuals with disabilities.

Gardner, Chapman, Donaldson, and Jacobson (1988) have identified strategies to educate and gain families' support during vocational training and after placement in a community job. If the disability service delivery system is to become more multicultural, it will continue to look for strategies which allow working through families and working with families.

Peer Support and Consumer Involvement

Peer support is another trend in the disability service delivery system that may be particularly appropriate for those from cultures that value affiliation. In one of the more comprehensive books on peer counseling in adult settings (D'Andrea & Salovey, 1983), the three major areas of emphasis were (a) basic helping skills, (b) crises counseling, and (c) overcoming the barriers of cultural differences which exist between human service agencies and some of the persons they attempt to serve. Weidman (1986) introduced the concept of a "culture broker" as an intermediary for working with culturally different clients. The training of helpers who are indigenous to the population being helped was popularized by Carkhuff & Truax (1965) and validated by researchers from several disciplines.

Peer Counseling is a mandated service in independent living centers and is becoming much more wide-spread in other components of the disability service delivery system. The use of natural supports in the workplace is one of the more exciting initiatives in supported employment (Hagner, Rogan, & Murphy, 1992). The use of supportive persons in the workplace is effective whether the issue is severity of disability, cultural diversity, or both.

Organizational Development

Many of the activities of rehabilitation counseling are specified by legislation and regulations. "...most of us learn very quickly on the job that federal disability policy and legislation define rehabilitation practice" (McCrone, 1991, p. 16). Fortunately, current legislation encourages the use of state-of-the-art professional practice. It has often been pointed out, however, that some vocational rehabilitation agencies develop policies and procedures for reasons that have nothing to do with the people they serve (Berkowitz, 1987). Therefore, improving services that impact on employment outcomes for people with severe disabilities--especially those from culturally diverse backgrounds--involves more than improving the professional practice of individual service providers. The previous chapter, suggests how to develop and manage organizations which optimize the professional development of service providers. The Human Resources Development and Human Resources Management Initiatives of the Rehabilitation Services Administration (Pacinelli & Stude, 1992) supports this goal. Nothing less than a continuous and pro-active program to develop the organization's capacity to facilitate the independent living and career development of persons with disabilities who are members of minority groups, is acceptable.

Community Development

Kuehn (1991) points out that environments which handicap people with disabilities require correction at the community level even though disability policy has usually focused on the individual's limitations rather than the attitudinal and architectural barriers in the community. Passage of the Americans With Disabilities Act of 1990 provided communities with a set of criteria for evaluating their responsiveness to the needs of people with disabilities.

As traditional rehabilitation agencies have expanded to provide a comprehensive program of services, family and community support systems have received more attention. Supported and transitional employment, independent living centers, Projects With Industry, innovative technology, and other community-based programs have all emphasized the important role the community plays in habilitation and rehabilitation. As the trend continues to capitalize on the natural supports in the workplace and in the community, rehabilitation service providers will take on more of the role of community development consultant (Hagner, Rogan, & Murphy, 1992).

Implications and Conclusions

It is only within the unifying concept of the total community (social system) that the diversity among individuals can be fully appreciated. The guarantee of individual freedom and equality, by virtue of our social contracts (e.g., Declaration of Independence, Constitution, Bill of Rights, Civil Rights Legislation, United Nations Charter) is only as strong as our collective sense of community. The underlying principle is that each and every person in most cultures is of equal value, and no one may be sacrificed for the group. This obliges the community to make a place for everyone. Since each person is of equal value, then each person is of ultimate value. Repeated observation of how individuals from diverse cultural backgrounds construct themselves builds awareness of how all people are alike in constructing themselves from their particular cultural milieu. Both "ours" and "theirs" are based on assumptions and, therefore, are subject to further study.

Chapter Six

Recommendations

Recommendations

Objectives

1. To present a three-step model for moving a State/Federal vocational rehabilitation agency toward being culturally-responsive
2. To present a strategy for pre-service educators on how to update current courses to include curriculum emphases which will enhance the development of culturally-competent rehabilitation professionals
3. To present a recommended training philosophy involving three seminars to further develop cultural competence in the rehabilitation professional

Summary

It would be a futile academic exercise to discuss cultural diversity without summarizing specific implications and recommendations for the field of rehabilitation. This document discusss historical precedents (Chapter II), systemic barriers (Chapter III), systemic issues (Chapter IV), and strategies (Chapter V) which enhance services to culturally-distinct populations, encourages the development of a rehabilitation process which values cultural diversity, and professionals seeking "cultural competence." Cultural competence is

> ...the ability of individuals to see beyond the boundaries of their own cultural interpretations; to be able to maintain objectivity when faced with individuals from cultures different from their own; and to be able to interpret and understand the behaviors and intentions of people from other cultures nonjudgmentally and without bias. (Walker, 1991, p. 6)

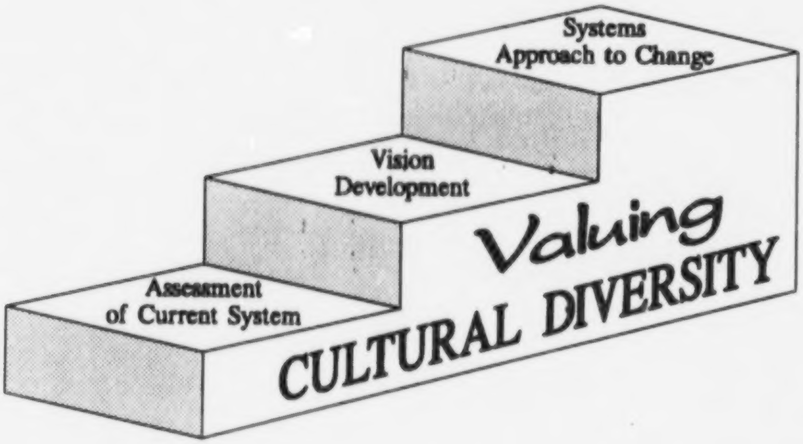
This chapter presents recommendations in respect to (a) achieving a culturally-responsive rehabilitation system, and (b) the development of culturally-competent rehabilitation practitioners.

Discussion

Culturally-responsive Rehabilitation System

A culturally-responsive rehabilitation system (a) encourages rehabilitation professionals and consumers to see beyond their own cultures; (b) has policies and procedures which reflect the value of those who are culturally diverse; and (c) has policies and procedures which respond effectively to cultural diversity. To develop such a culturally-responsive system, three steps are suggested (see Figure VI-1). They are: (a) an assessment of the current rehabilitation system; (b) a commitment to a vision that cultural diversity is valued and the translation of such a vision into goals; and (c) a systems approach to changing policies and procedures which do not compliment this vision to achieve equity in service quality.

Figure VI-1. Steps to Developing a Culturally-Responsive Rehabilitation System



Assessment. An assessment of the current rehabilitation system is needed and a strategic planning approach is encouraged. Strategic planning is a process originally developed in the military but has found application in both the private and public business sectors. The outcome of strategic planning is a vision, mission statement, goals, and objectives which are compatible with the anticipated external environment and desired internal environment of an organization.

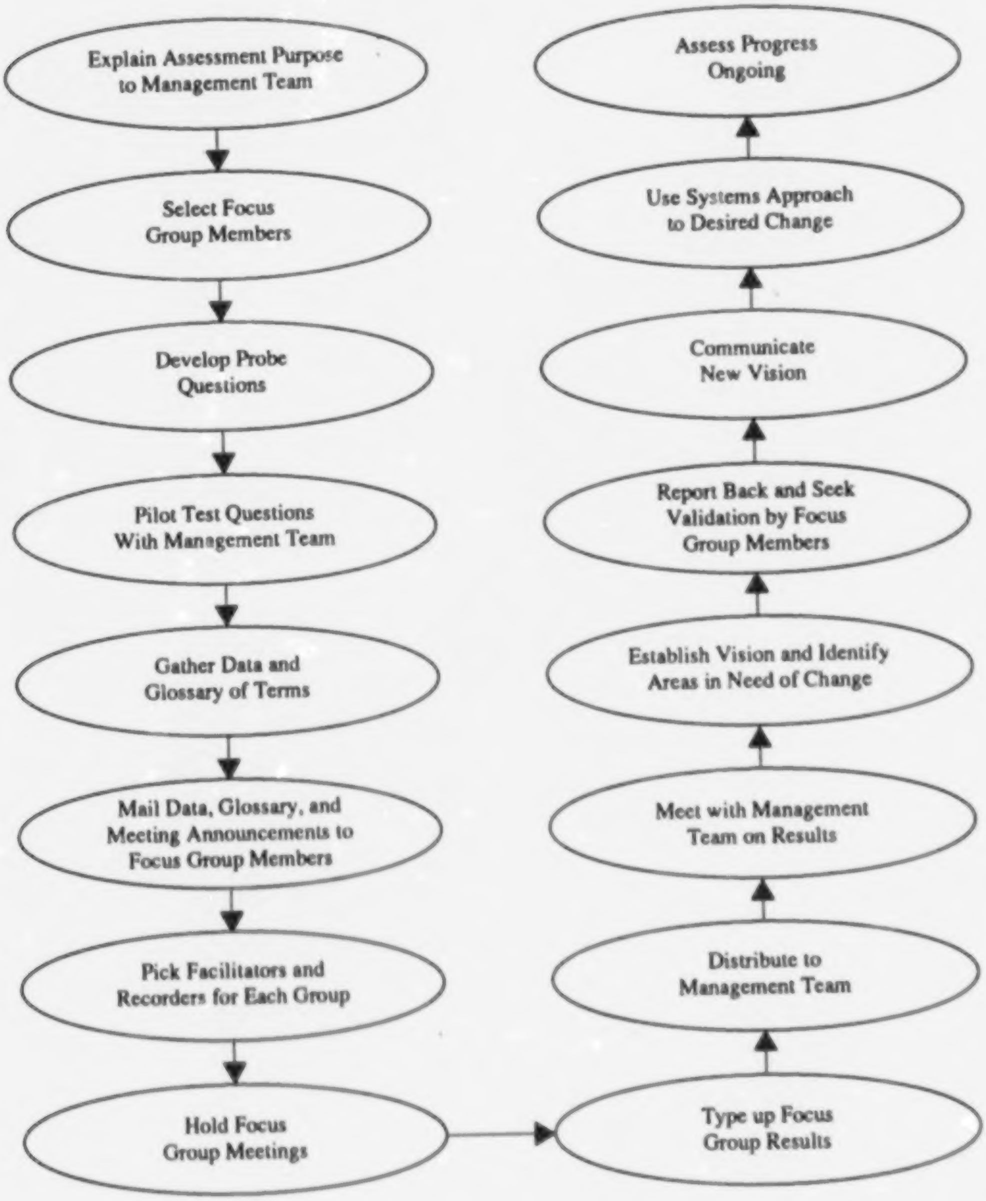
This strategic planning process typically includes assessing strengths, weaknesses, opportunities, and threats (McDonald, 1984). In this case such assessment would focus on an individual state agency's responsiveness to cultural diversity. It is recommended that each State/Federal rehabilitation agency complete its own assessment, as the majority culture may differ considerably between states and/or locales.

One process for completing this assessment involves the development of focus groups (see Figure VI-2) representing all persons affected by the rehabilitation program. Focus groups are made up of persons representing all facets of the community. The optimal size of each focus group is 11-15 persons indicating the need for more than one focus group to obtain adequate representation. At least eight focus groups are needed and would include:

- representation of all levels of employees within the State/Federal agency (four different focus groups, e.g., one for counselors, one for program specialists, one for management, and one for clerical personnel);
- staff from the regional Rehabilitation Services Administration (RSA) office (one focus group);
- consumers (one focus group);
- employers (one focus group);

- rehabilitation community at large such as client assistance program staff, independent living center staff, facilities staff, rehabilitation educators, and the regional Rehabilitation Continuing Education Program staff (one focus group).

Figure VI-2. Assessment Process Approximately an Eight-month Process


Explain Assessment Purpose to Management Team
Select Focus Group Members
Develop Probe Questions
Pilot Test Questions With Management Team
Gather Data and Glossary of Terms
Mail Data, Glossary, and Meeting Announcements to Focus Group Members
Pick Facilitators and Recorders for Each Group
Hold Focus Group Meetings
Type up Focus Group Results
Distribute to Management Team
Meet with Management Team on Results
Establish Vision and Identify Areas in Need of Change
Report Back and Seek Validation by Focus Group Members
Communicate New Vision
Use Systems Approach to Desired Change
Assess Progress Ongoing

Usually each focus group meets for 1-2 days of discussion and is directed by a trained facilitator with a recorder/secretary along with a set of questions for stimulating the discussions. The focus groups should have access to data regarding ethnicity of successful closures, cases closed, "revolving door" clients, staffing patterns within the agency, and general population demographics prior to attending their focus group sessions. Also, it would be helpful for the participants to receive a glossary of terms prior to participating in their focus group sessions. Sample probe questions are listed below, but it is suggested that the questions be tailored to the specific focus group's orientation.

1. What is the majority culture in this state and this agency?
2. What policies and/or procedures are encouraging participation of persons from other cultures?
3. What does the agency need to continue to change to become more culturally-responsive?
4. What suggested activities need to be prioritized for implementation in the next 12 months?

By completing this assessment, rehabilitation management teams should be able to determine if their system only reflects the values of the majority culture, does or does not respect cultural diversity, and is or is not endorsing assumed similarity.

> Assumed similarity is the result of an environment which intentionally or non-intentionally, causes a lack of desire to understand accurately those who are socially and culturally different. (Vacc, Wittmer, & DeVany, 1988, p. 4)

A vision that diversity is valued drives the strategic planning approach. Therefore, each focus group should develop a proposed vision statement. Priority activities are then needed to provide management with concrete directions.

A vision. Moving toward (or in some State/Federal agencies, maintaining) a vision that diversity is valued is the recommended vital second step in assuring a culturally-responsive rehabilitation system. Once America was considered a melting pot of cultures. The melting pot concept was based on the belief that people needed to adopt the majority cultures' values, attitudes, and beliefs. Our nation now needs to value the idea of a "stew" of cultures (Miller, 1988, p. 197). This "stew" philosophy allows the individual to be a valued part of the whole as well as to maintain the desired cultural identification, and thus alleviate the devastating influences of oppression.

We must value the differences which pluralism brings and share the vision that cultural diversity is valued. "To value workforce diversity is to manage in a way designed to seize the benefits that differences bring" (Copeland, 1988, p. 52). There is evidence that the State/Federal rehabilitation program is moving toward valuing cultural diversity. The RSA national short-term training priorities for 1992-1993 involve a cultural diversity initiative, and this report from IRI addresses this topic. At the National Rehabilitation Counseling Association's professional development symposium (NRCA, 1990) RSA Commissioner Nell Carney shared the need for pre-service coursework to integrate multicultural issues into core courses, and funding continues for rehabilitation programs for Native Americans, migrants, and culture specific research and training centers such as Howard University's program.

Systems approach to change. The third step in developing a culturally-responsive rehabilitation system is to use a systems approach to creating change. By endorsing a systems approach, a broader strategy for change is valued and therefore possible. (For further information on a systems approach the reader is encouraged to review Carlisle, 1981.) Current rehabilitation examples of the systems change approach would be the marketing approach to placement, implementing total quality management strategies, and/or the transition from menu driven training programs to a human resource management system.

This section presented three steps to developing a culturally-competent rehabilitation system. They were (a) assess each State/Federal rehabilitation agency using a strategic planning process; (b) developing a commitment to a vision that cultural diversity is valued; and (c) use a systems approach to change inhibiting policies and procedures. Attention will now shift toward the development of culturally-competent rehabilitation professionals.

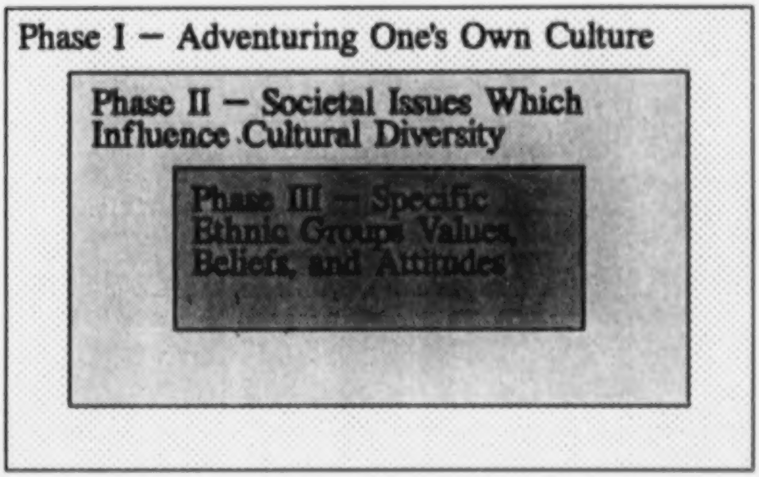
Culturally-competent Rehabilitation Professionals

There are many influences on the development of a rehabilitation professional's skills, knowledge, and competence. Key factors would be the professional's own culture (inclusive of attitudes, values, and beliefs), pre-service educational opportunities, employment environments, coworkers' attitudes and beliefs, and post-employment training activities. This section's recommendations for developing culturally-competent rehabilitation professionals will concentrate on pre-service education and post-employment training opportunities.

Pre-service education. Whatever the formal educational exposure (i.e., graduates of programs accredited by the Council on Rehabilitation Education [CORE] or related degrees) Dodd, Nelson, Ostwald, and Fischer (1991) state that the "...programs need to address issues from a multicultural approach to prepare effective rehabilitation counselors for an increasingly pluralistic society" (p. 46). Pre-service education can develop specific courses to address cultural issues. Many professionals have advocated that a specific program needs to be required in CORE programs regarding pluralism and practicum assignments deliberately cultivated with multicultural exposure (Dodd, et al., 1991). On the other hand it may be more effective and appropriate to explore 'culture' within each class in the existing curriculum where material will be more relevant. Many attempts to develop a counseling student's multicultural skills and a value of cultural diversity have concentrated on learning more about varying ethnic groups' values, attitudes and beliefs. This knowledge-building is critical but should always be based on the students' self-understanding and awareness of their own culture. Three courses (see Figure VI-3) are being recommended, or the tailoring of currently approved seminars to represent these subjects.

The fundamental assumption is that the first phase of course work must promote an understanding by each student of his/her own attitudes, beliefs, and values. If self-analysis does not occur before learning about varying ethnic groups, then the student may assume similarity. "The consideration of values in counseling practice is essential since a counselor must always attempt to understand his/her own internalized system of values and avoid attempting to impose those values on the person with whom he/she is working." (Lowery, 1983, p. 71)

Figure VI-3. Topical Emphasis for Rehabilitation Course Offerings


Phase I — Adventuring One's Own Culture
Phase II — Societal Issues Which Influence Cultural Diversity
Phase III — Specific Ethnic Groups Values, Beliefs, and Attitudes

The second phase of pre-service education would concentrate on the societal issues which influence a professional's, often unconscious, confusion toward valuing cultural diversity. The influence of oppression, assimilation, poverty, educational opportunities, family structure, language differences and the majority's cultural values in rehabilitation service delivery need to be topical issues for learning activities. "It is not enough for a counselor to be tolerant of another culture; he/she must know enough about it to be respectful and must understand how much his/her own behavior and agency procedures are extensions of his/her culture which may create problems for clients." (Lowery, 1983, p. 72) After completing the first two phases of study, a rehabilitation student would be prepared to learn about specific ethnic groups.

The third phase of educational preparation would emphasize knowledge-building regarding specific ethnic groups' values, attitudes, and beliefs, At a minimum, concentration would be on attitudes toward disability, family roles, work ethics, orientation to time, acculturation patterns, religion, the role of the "helper," and attitudes toward government-funded services. By using this three-phase approach to course work and/or seminar development, rehabilitation educators would be confident that they have attempted to eliminate the propagation of cultural oppression (Sue, 1978) in the rehabilitation delivery process by appropriately educating qualified rehabilitation professionals for employment in a system which values cultural diversity.

We cannot move onto post-employment issues without discussing (a) the lack of representation of diverse cultures in hiring and the retention of rehabilitation educators, and (b) the need for more culture specific research. Examples of encouraging developments include the following: (a) Wright (University of South Florida, Tampa) received a grant to recruit more minorities into the field of rehabilitation counseling, and (b) Rubin (Southern Illinois University at Carbondale) coordinates a fellowship program funded by the US Department of Education which allows for recruitment of minority students into the doctoral rehabilitation program. Also, most rehabilitation counseling programs have successfully utilized ethnic guest speakers when needed, and this practice is also encouraged to continue. Additional funding for more graduate level programs which emulate Wright's and Rubin's minority recruitment philosophies is also recommended.

The National Council of Rehabilitation Educators (NCRE) is encouraged to support post-employment training opportunities for current educators which coincide with the three phases of course work discussed in this section. The ideal would be to have diverse ethnic representation in the field of rehabilitation education. However, having educators who value cultural diversity in educational preparation and service delivery would be a current demonstration of excellence in the field.

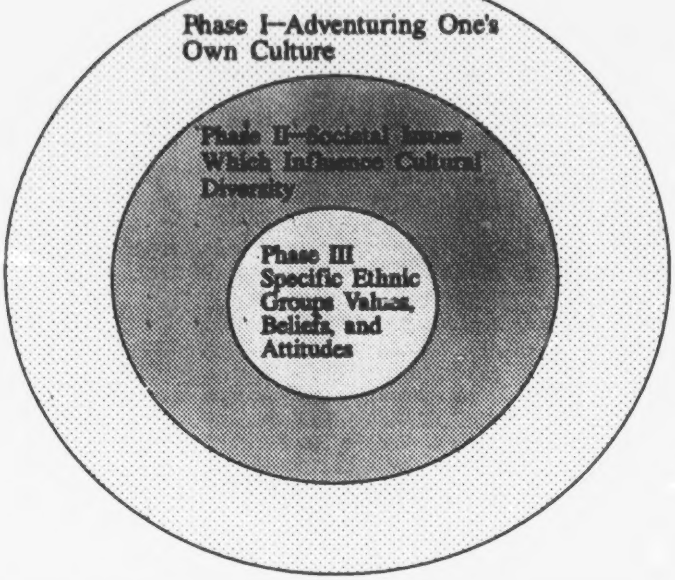
Ethnographic research can be viewed as an in-depth analytical description of a cultural scene. The advantages of this type of research include: (a) a longitudinal perspective of a complete environment; (b) a lead into new insights and hypotheses; and (c) hypotheses that are developed after study and are based on solid observation, which allows for phenomena not to be overlooked due to pre-established hypotheses (Borg & Gall, 1983). Research using ethnographic methods is encouraged as it might uncover new phenomena regarding rehabilitation service delivery and the value of cultural diversity.

It is also recommended that NCRE and/or RSA support research activities which review all the "Code of Ethics" within the rehabilitation industry to see if the value of cultural diversity is supported by such "Codes." Revising the "Codes" where needed to reflect the value of cultural diversity would be the intended outcome of the research activities. Reliance on other professional codes, such as the American Psychological Association's code, may prove a helpful framework for making revisions.

Post-employment opportunities. Traditionally, there are three environments in which post-employment human resource development activities occur within the rehabilitation community: (a) activities and strategies planned by the State/Federal agency human resource development departments and called in-service training, (b) activities coordinated by the RSA funded Regional Rehabilitation Continuing Education Programs and/or Research and Training Centers, and (c) professional organizations' state and national conferences, most typically those of the National Rehabilitation Association. Annually, RSA also funds national short-term training initiatives. The rehabilitation professional has a number of opportunities for post-employment training or human resources development, and RSA is complimented for its commitment and resources for such programs.

It is recommended that the three-phases approach to learning, which was advocated in the pre-service section of this chapter, be made available for in-service training (see Figure VI-4). "Within the rehabilitation services delivery process, both the service delivery professional and the client may be bound by their own cultural assumptions" (Walker, 1991, p. 6). The level of interventions discussed here can be successful if the agency has communicated the value of cultural diversity.

Figure VI-4. Strategy for Training Seminars


Phase I—Adventuring One's Own Culture
Phase II—Societal Issues Which Influence Cultural Diversity
Phase III Specific Ethnic Groups Values, Beliefs, and Attitudes

The first phase of training needs to concentrate on the professionals' becoming aware of their own cultural influences, attitudes, beliefs, and values. An awareness of one's own culture enables the professional to recognize a tendency to develop a one-model approach in service delivery. "A counselor who assumes that he can provide effective assistance to individuals across ethnic boundaries without changing his one-model approach is either unable or unwilling to recognize cultural and ethnic difference" (Pedersen, 1976, p. 17). A minimum of a one-day awareness workshop format is recommended for this phase of cultural diversity training.

The activities of awareness training should include an evaluation of the professional's cultural awareness of work ethic, health and disability factors, orientation to time, and efforts to seek services from government funded programs. It may be helpful to use pre and post assessments to determine the value of the program. However, existing work groups should not be used if they reinforce old, inappropriate relationships, as suggested by Weigel and Howe (1985). Members of work groups should have equal status and common goals supported by group norms.

Multicultural counseling is defined by Lee as "an intervention process that places equal emphasis on the racial and ethnic impressions of both counselor and client" (1991, p. 229). Most past cultural diversity training has taken the "quick fix" approach by concentrating on information building regarding ethnic groups (Phase III only). A concentration on the professional's own culture must precede such knowledge building.

The second phase of training would be a two-day seminar concentrating on barriers resulting from the majority culture's influence upon the State/Federal rehabilitation program and philosophy. This phase would provide the basis for effective generalization of knowledge to cultures which could not be studied specifically. The qualities of effective counseling and a commitment to the helping relationship should also be revisited in this phase of training.

The third phase of training may employ a two or three-day seminar covering the values, attitudes, and beliefs of varying ethnic groups. Emphasizing the ethnic group's values regarding work, health and disability, orientation to time, family roles, and seeking services from government funded programs is recommended. Increasing the professional's knowledge of a person's culture will help the rehabilitation counselor in his/her work role (Rivera & Cespedes, 1983). Use of guest speakers and field trips to ethnic neighborhood programs are encouraged in this phase of training. Walker (1991) presented a cultural template and series of focus questions to guide the counseling relationship. Review of this template would further facilitate the topical selections and training activities for this third phase of training. Other resources for training activities would be the handbooks of training activities on cultural awareness developed by Pedersen (1988) and/or Simons (1989). Also, a complete training package that includes video presentations is available from US Learning Corporation (see reference list). That package compliments this document's training philosophy.

This three-phase training approach may be most effectively implemented over a time period of 12 to 18 months. Ongoing training activities must be incorporated in all future training strategies for successful impact to occur. The development of culturally-competent rehabilitation professionals should not be viewed as a short-term training mission but a long-term process.

Harper and Fischer (1979) completed a study on the white and nonwhite client in the rehabilitation setting. They concluded that white counselors are able to effectively help clients of minority cultures if the counselors had:

> (a) knowledge of the client's culture and background, (b) effective communication and understanding of ethnic language, (c) personality qualities of effective counseling, (d) a commitment to the helping relationship, and (e) an openness to the nonwhite as a unique person, not a stereotypical image. (p. 355)

Harper and Fisher's conclusions reflect the training objectives of this three-phase approach to multicultural counseling.

Implications and Conclusions

This chapter presented recommendations and implications regarding (a) a culturally-responsive rehabilitation system, and (b) culturally-competent rehabilitation practitioners. A three-step model was suggested for the development of a rehabilitation system which values cultural diversity. The first step was the assessment of rehabilitation agencies, using a strategic planning process. The second step involved the development of commitment to a vision of cultural diversity. The third step briefly describes the systems approach to change and how it might be utilized to facilitate implementation and development.

In relation to professional development, pre-service and post-employment learning opportunities were discussed. A three-step process was presented for both levels. Specific recommendations were provided to rehabilitation educators regarding recruitment of ethnic students and educators as well as the applicability of appropriate research. Both NCRE and RSA were encouraged to research the current rehabilitation community's "Codes of Ethics" for demonstration of a commitment to valuing cultural diversity.

There were three philosophies which supported all the recommendations in this section. They were: (a) "If one is to respond to the value system of another culture, the system must also indicate the behavior of the counselor for a productive helping profession..." (Lowery, 1983, p. 72); (b) "An operational objective of counseling culturally diverse clients is helping them empower themselves for environmental mastery and competence" (Lee, 1991, p. 229); and (c) "Both the individual and the subgroup must be the unit of consideration" (Vacc, Wittmer, & DeVany, 1988, p. 8).

Chapter Seven

Resource Guide

Resource Guide

Objectives

1. To provide the reader with possible resources which may prove helpful to the rehabilitation professional in obtaining more information about the value of cultural diversity

2. To provide the reader with a list of different resources which facilitate learning about specific ethnic beliefs, attitudes and values

3. To provide the reader with a list of resource people who may be able to clarify specific cultural issues which could influence the rehabilitation system's value of cultural diversity

Summary

There is a multitude of federal, state, local, public, and private resources for providers of rehabilitation services to individuals from culturally diverse backgrounds. This chapter presents a variety of resources for service providers and individuals from the diverse cultures they serve. Throughout this document the importance of establishing a broad and diverse base of resources and of planning and initiating training in cultural diversity in rehabilitation is stressed.

Discussion

Introduction

The resource section is divided into four areas for the convenience of the reader who is searching for information on serving individuals with severe disabilities from different cultures. These areas are:

1. Independent and consulting firms

2. National Institute on Disability and Rehabilitation Research (NIDRR)

    - Research and Training Centers in Rehabilitation
    - NIDRR contracts
    - ADA Technical Assistance Programs

3. Rehabilitation Services Administration (RSA)

    - Long-term training projects
    - Experimental and innovative programs
    - Rehabilitation Continuing Education Programs
    - Interpreter training for individuals with hearing impairments

4. References

- Books
- Monographs
- Periodicals
- Films/videotapes

Consulting Firms

Many excellent consulting firms across the country provide information, training, and resources for public and private agencies concerned with cultural diversity. Since a complete list and description of these firms could involve several volumes, only a representative sample will be listed here. These firms provide services such as training, consultation, information, and referral. Although areas of emphasis vary significantly, all these firms address cultural diversity in some form or fashion.

Some firms provide information in different languages including Spanish and French. Some provide services that include technical assistance, on-site research, leadership, communication, development of policies and practices, and organizational structures. A number of the firms provide training of varying duration and on various topics. Most of them are programs of a general nature; however, several of these firms will develop programs specifically related to an agency, organization or corporation. Additional information can be obtained by contacting firms from the list provided.

The American Institute
for Managing Diversity
P. O. Box 38
830 Westview Drive, SW
Atlanta, GA 30314
404/524-7316

American Training Systems (ATS)
Managing Partners
100 Marin Center Drive, Suite 6
San Rafael, CA 94903
415/749-6631

Pat Arnold & Associates
3000 Hillsboro Road, Suite 105
Nashville, TN 37215
615/383-9791

Elsie Y. Cross, Inc.
7627 Germantown Avenue
Philadelphia, PA 19118
215/248-8100

Executive Diversity Services, Inc.
10311 20th Street, NE
Seattle, WA 98125
206/522-6267

The Intercultural Communication Institute
8835 SW Canyon Ln, Suite 238
Portland, OR 97225
503/297-4622

Jamieson Consulting Group
2265 Westwood Boulevard, Suite 310
Los Angeles, CA 90064
310/397-8502

Job Accommodation Network
WVU-809 Allen Hall
Morgantown, WV 26506
US 800/526-7234
Canada800/526-2262

Phoenix Associates, Inc.
11204 East Steamboat
Tempe, AZ 85283
602/831-1911

The US Learning Corporation
11150 Foothill Boulevard
Suite R
La Canada, CA 91011
800/869-1310

Risa Martyn Communications, Inc.
52 Longview Avenue
San Anselmo, CA 94960
415/457-8344

The National Institute on Disability and Rehabilitation Research

NIDRR
Office of Special Education and Rehabilitation Services
US Department of Education
400 Maryland Avenue, SW, MS 2305
Washington, DC 20202
202/732-1134

Research and Training Centers (RTCs)

NIDRR provides funding for the research and training centers. The stated goals of the RTCs are:

- To conduct research targeting the production of new knowledge which will improve rehabilitation methodology and service delivery systems, alleviate or stabilize disabling conditions, and promote maximum social and economic independence
- To initiate related teaching and training programs to disseminate and promote the use of research findings, thereby reducing the usual long intervening delay between the discovery of new knowledge and its wide application in practice

The three major activities--research, training, and service--are expected to be mutually supportive. Specifically, this synergy calls for research ideas to be derived from service delivery problems, for research findings to be disseminated via training, and for new professionals to be attracted to research and service via training.

Since a rather significant number of RTCs exist, only those concerned with cultural diversity will be listed. Their addresses, phone numbers, and major objectives will be presented. Additional information can be obtained by contacting the specific RTC or by contacting the NIDRR office.

American Indian Research and Training Center
Northern Arizona University
Institute for Human Development
NAU Box 5630
Flagstaff, AZ 86011
602/523-4791
Objective: to survey disabled American Indian populations and analyze their labor market conditions.

Native American RTC-Improving Rehabilitation of American Indians
1642 East Helen Street
Tucson, AZ 85719
602/621-5075
Objective: to design and establish culturally sensitive programs for rehabilitation of Native Americans with disabilities.

RTC in Public Policy on Independent Living
World Institute on Disability
510 16th Street
Oakland, CA 94612
415/763-4100
Objective: to develop and evaluate strategies and policies for independent living programs.

Pacific Basin Research and Training Center
University of Hawaii
Rehabilitation Hospital of the Pacific
226 Kuakini Street
Honolulu, HI 96817
808/537-5986
Objective: to conduct research, training, and disseminate information on rehabilitation problems of individuals with disabilities in the Pacific Basin.

RTC for Access to Rehabilitation and Economic Opportunity
Howard University*
School of Education
2400 6th Street, NW
Washington, DC 20059
202/806-8727
Objective: to conduct research on the incidence of disability among economically disadvantaged persons.

An increase in culturally relevant services and improved service delivery will facilitate successful employment, economic independence and social adjustment by persons with disabilities from culturally diverse backgrounds. Minority persons with disabilities become more responsive to therapy, research and intervention and are more receptive to treatment when their lifestyles are respected. The proposed rehabilitation project by Howard University is designed to facilitate more effective vocational rehabilitation outcomes for persons from diverse backgrounds (including African Americans, Hispanics, Asian Americans, Native Americans and Pacific Islanders).

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* Readers may be interested in a special project initiated by Howard University and a number of cooperating organizations in 1992-Embracing diversity: The multicultural rehabilitation model.

NIDRR Contracts

Alaska Assistive Technology Project
Department of Education
Division of Vocational Rehabilitation
400 D Street, Suite 230
Anchorage, AK 99501
907/274-0138
Objective--to expand the availability of assistive technology through a comprehensive, consumer-responsive, statewide program of technology-related services.

Hawaii Assistive Technology System for Persons with Disabilities
Department of Human Services
Vocational Rehab & Services for the Blind
1000 Bishop Street, Room 605
Honolulu, HI 96813
808/586-5375
Objective--to expand the availability of assistive technology services and devices through a comprehensive consumer-responsive statewide program of technology-related assistance.

American Indians with Disabilities Public Awareness Campaign
Alaska Public Radio Network
National Native News
810 East 9th Avenue
Anchorage, AK 99505
907/277-2776
Objective--to establish a model public awareness program to build awareness of the importance of assistive technology in the lives of American Indians with disabilities.

Model Technology Training Modules for Blacks and Hispanics with Low-incidence Disabilities
RESNA
1101 Connecticut Avenue, NW, Suite 700
Washington, DC 20036
202/857-1140
Objective--to develop curricula and training individuals with disabilities, their families or representatives regarding the provision, benefits, and uses of assistive technology; to develop, test, implement, and disseminate models of technology assistance for low-incidence disability groups.

ADA Technical Assistance Programs

The Americans with Disabilities Act (ADA) opens new opportunities for persons with disabilities. It also places new responsibilities on employers, transit and communication systems, state and local governments, and public accommodations. To assist affected parties to understand and comply with the ADA, NIDRR has funded ten Regional and Business Accommodation Centers. These centers will provide technical assistance, training and resource referral on all aspects of ADA. (In addition, seven other NIDRR programs were funded with two related to ADA programs, three to materials development projects, and two to national peer-training projects.) These centers are listed below by RSA region, followed by the special projects. Only the name of the center, address and phone number are provided. Additional information can be obtained by contacting the center, project, or NIDRR.

Region I
New England Disability and Business
Technical Assistance Center (TAC)
University of Southern Maine/
Muskie Institute
96 Falmouth Street
Portland, ME 04103
207/780-4430

Region II
Northeast Disability and Business TAC
United Cerebral Palsy Association of NJ
354 South Broad Street
Trenton, NJ 08608
609/392-4004

Region III
Mid-Atlantic Disability and Business TAC
Endependence Center of Northern Virginia
2111 Wilson Boulevard
Arlington, VA 22201
703/525-3268

Region IV
Southeast Disability and Business TAC
United Cerebral Palsy Association/National
Alliance of Business
1776 Peachtree Road, Suite 310 N
Atlanta, GA 30309
404/888-0022

Region V
Great Lakes Disability and Business TAC
University of Illinois/Chicago
University Affiliated Program in
Developmental Disabilities
1640 West Roosevelt Boulevard
Chicago, IL 60608
312/413-1647

Region VI
Southwest Disability and Business TAC
The Institute for Rehabilitation Research
2323 South Shepard Boulevard, Suite 1000
Houston, TX 77019
713/520-0232

Region VII
Great Plains Disability and Business TAC
University of Missouri/Columbia
310 Jesse Hall
Columbia, MO 65211
314/882-3807

Region VIII
Disability and Business TAC
Meeting the Challenge
3630 Sinton Road, Suite 103
Colorado Springs, CO 80907
719/444-0252

Region IX
Pacific Coast Disability and Business TAC
Berkeley Planning Associates
440 Grand Avenue, Suite 500
Oakland, CA 94610
415/465-7884

Region X
Northwest Disability and Business TAC
Washington State Governor's Committee
on Disability Issues and Employment
212 Maple Park KG-II
Olympia, WA 98504
206/438-3168

NIDRR Funded Related Projects

ADA Materials Development Project
Related to Employment
Cornell University
120 Day Hall
Ithaca, NY 14853
605/255-9563

Peer Training Project-Local Capacity
Building in ILCs
National Council on Independent Living
3607 Chapel Road
Newtown Square, PA 19073
215/353-6066

ADA Materials Development Project
Related to Employment
International Association of Machinists
Center for Administration of Rehabilitation
Employment Services
1300 Connecticut, NW Suite 912
Washington, DC 20036
202/857-5173

ADA Materials Development Project
Relating to Public Accommodations &
Accountability
Barrier Free Environment, Inc.
Water Garden, Highway 70 West
Raleigh, NC 27622
603/224-7005

Rehabilitation Services Administration (RSA)

Office of Special Education and Rehabilitation Services
US Department of Education
Switzer Building
330 C. Street, SW
Washington, DC 20202
202/732-1406

The RSA supports many programs that are designed to improve the skills and expertise of rehabilitation professionals. A listing of these programs can be obtained by contacting RSA. RSA collaborates closely with NIDRR, CSAVR, and state agencies in the area of cultural diversity.

Only a few of these programs are listed here and in no way are they intended to represent superior programs. Instead, they are presented as examples of programs that do exist and are supported by RSA.

Undergraduate Education

University of Texas--Pan American
Rehabilitative Services Program
1201 W. University Drive
Edinburg, TX 78639
512/381-2291

University of Georgia
Rehabilitation Counseling
413 Aderhold Hall
Athens, GA 30602
404/542-2597

Pennsylvania State University
University Park
Div. of Counseling & Educational
Psychology
248 Calder Way, Suite 300
University Park, PA 16802
814/863-2416

University of North Texas
Center for Rehabilitation Services
P. O. Box 13438
Denton, TX 76203
817/565-2488

Long-term Training--Counseling
Springfield College
263 Alden Street
Springfield, MA 01109
413/788-3318

Rehabilitation Counseling--Masters

Rehabilitation Counseling Program
South Carolina State College/Orangeburg
300 College Street, NE
Orangeburg, SC 29117
803/536-8900

School of Education/Counselor Education
Portland State University
P. O. Box 751
Portland, OR 97207
503/725-4750

Department of Rehabilitation Counseling
College of Arts and Sciences
University of South Florida
4202 East Fowler Avenue
SOC 107
Tampa, FL 33620-8100
813/974-2855
FAX 813/974-2668

Rehabilitation Counseling Program
New York University/SEHNAP
50 West 4th Street, Room 432
New York, NY 10003
212/998-5293

Sponsored Research Office-T605
George Washington University
Academic Ctr., 801 22nd St., NW
Washington, DC 20052
202/994-7204

Rehabilitation Counseling--Doctoral

Board of Regents
University of Wisconsin
750 University Avenue
Madison, WI 53706
608/262-3822

Division of Special Education & Rehabilitation
University of Arizona
College of Education
Tucson, AZ 85721
602/621-1549

University of Arkansas-Fayetteville
Research & Training Center in
Vocational Rehabilitation
West Avenue Annex
Fayetteville, AR 72701
501/575-3656

Rehabilitation Continuing Education Programs

Region I
Rehabilitation Continuing Education Program
Institute/Social & Rehabilitation Services
500 Salisbury Street
Worchester, MA 01609
207/508-0677

Region II
Rehabilitation Continuing Education Program
SUNY Res Fnd/University of New York
P. O. Box 9
Albany, NY 12201
716/636-2517

Region III
Rehabilitation Continuing Education Program
The George Washington University
Office of Sponsored Research
Rice Hall, 6th Floor
Washington, DC 20052
212/676-5929

Region IV
Rehabilitation Continuing Education Program
University of Tennessee
College of Education
404 Andy Holt Tower
Knoxville, TN 37996
615/974-8111

Region V
Rehabilitation Continuing Education Program
Southern Illinois University
C/O Research and Development
Carbondale, IL 62901
618/453-5744

Region VI
Rehabilitation Continuing Education Program
University of Arkansas-Fayetteville
P. O. Box 1358
Hot Springs, AR 71902
501/624-4411

Region VII
Rehabilitation Continuing Education Program
University of Missouri
Grants & Contracts Administrati
305 Jesse Hall
Columbia, MO 65211
314/882-3807

Region VIII
Rehabilitation Continuing Education Program
University of Northern Colorado
Department of Human Services
McKee Hall, Room 44
Greeley, CO 80639
303/351-1586

Region IX
Rehabilitation Continuing Education Program
San Diego State University
College of Education
San Diego, CA 92182
619/655-4207

Region X
Rehabilitation Continuing Education Program
Seattle University
Department of Rehabilitation
12th & East Columbia
Seattle, WA 98122
206/296-5650

Books, Articles and Publications

The area of cultural diversity has been deluged of late with articles, books, documents and monographs regarding the impasse of diversity in rehabilitation. Seemingly, each major refereed journal has devoted an issue to this topic reflecting the fact that it is a concern of major proportion throughout the entire field of rehabilitation. Whether to compose a list of books, articles, etc., to present as suggested readings was discussed by the IRI Prime Study Group. The eventual decision was to exclude such a list because of the length and to recommend to the reader to review the comprehensive references in this document and/or obtain a copy of the Culture and Disability Bibliography published in January 1992 by the Pacific Basin Research and Training Center. Interested readers should address their request to:

Pacific Basin Research and Training Center
John A. Burns
School of Medicine, University of Hawaii
226 N. Kuakini Street, Room 233
Honolulu, HI 96817

The Massachusetts Rehabilitation Commission also published a bibliography of books and journal articles on cross-cultural counseling in 1984. Although a few years old now, interested readers may contact:

Library
Massachusetts Rehabilitation Commission
20 Park Plaza
Boston, MA 02116

The National Clearinghouse on Rehabilitation Training Materials (NCHRTM) is an excellent source of the latest information available on this or other subjects. Contact:

NCHRTM
816 W. 6th Street
Oklahoma State University
Stillwater, OK 74074

As mentioned previously, the reader can obtain information from NIDRR funded Research and Training Centers, especially special interest centers:

- American Indian Research and Training Center (p. 78)
- Native American Research and Training Center--Improving Rehabilitation of American Indians (p. 78)
- Research and Training Center in Public Policy (p. 78)
- Research and Training Center for Access to Rehabilitation and Economic Opportunity (p. 78)
- Pacific Basin Research and Training Center (p. 78)

Federal, regional and state vocational rehabilitation agencies are other sources of important information.

Videos, Films, and Other Media

As with the exploding number of publications on cultural diversity, the same is true of films, videos, and other types of media. Only a sample of what is available will be listed in this document. Readers are encouraged to contact RSA, NIDRR, CSAVR, independent consultants, and others listed in this chapter for additional information on the availability of media in the area of cultural diversity in rehabilitation.

Videos on cultural diversity may be obtained from:

BNA Communications, Inc.
9439 Key West Avenue
Rockville, MD 20850
800/263-6067
301/948-0540

BNA released a recent film designed to help managers and supervisors identify and solve workplace problems arising from cultural, racial, gender and language differences. The video, entitled Bridges: Skills for Managing A Diverse Workforce, is composed of eight modules:

Intercultural Perceptions	Module I: A Question of Honor
Gender Stereotypes	Module II: That kind of Woman
Subtle Racial Stereotypes	Module III: The Man in the Middle
Ethnic Identity/Organizational Culture	Module IV: The Choice I Make
Culture "In" Groups? "Out" Group	Module V: Come One, Come All
Intercultural Conflicts	Module VI: The Other Side of the Coin
Culture/Gender Stereotypes	Module VII: Drawing the Line
Communication Barriers	Module VIII: You Know What I Mean

In addition, numerous other videos on cultural diversity are available at nominal cost from BNA. Examples follow:

- We Look--You Look: Perspective on Acculturation
- Communicating with Native American Patients
- American Indian Concepts of Health and Unwellness
- Culture and Disability
- Cross-culture Perspective on Management and Supervision

A seven module video series is available from:

Griggs Production, Inc.
302 23rd Avenue
San Francisco, CA 94121
415/668-4200

Modules include:

Managing Diversity
Diversity at Work
Communicating across Cultures
You Make the Difference
Supervising Differences
Champions of Diversity
Profiles in Courage

Implications and Conclusions

In concluding this chapter on resources on cultural diversity it is evident that relevant resources do exist and new materials are being produced each day. Readers are reminded that increasing diversity in rehabilitation, the workforce, and society in general, presents many challenges to business, industry and State/Federal governments. The bottom line, however, is not just an awareness of cultural diversity but how differences are dealt with. Emphasis must be placed on knowledge, skills, and sensitivity.

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Appendices

Appendix A

Glossary

Africentric Orientation--The belief and orientation to African values and form manifested in contemporary African/American culture in spirituality, harmony, movement, verve affect communalism, expressive individualism, morality, and social time perspective.

Assimilation/Acculturation--The process in which successive generations of an immigrant or refugee group acquire the second culture, including the values, language, behaviors, and customs. The individual who adopts a second culture does not necessarily lose the original cultural learnings (e.g., Asian/American Culture).

Assumed Similarity--The result of an environment which intentionally or non-intentionally causes a lack of desire to understand accurately those who are socially and culturally different (Vacc, Wittmer, & Devany, 1988, p. 4).

Culture--The sum total of a way of living, including values, beliefs, aesthetic standards, linguistic expression, patterns of thinking, behavioral norms, and styles of communication. Culture is an interactive process (not static), which is continuous and cumulative. It includes demographic variables such as age, gender, place of residence, status variables such as social, educational, and economic levels, and affiliation variables that may be formal memberships or affiliations.

Cultural Competence--The "ability of individuals to see beyond the boundaries of their own cultural interpretations; to be able to maintain objectivity when faced with individuals from cultures different from their own; and the ability to interpret and understand the behaviors and intentions of people from other cultures non-judgmentally and without bias" (Walker, 1991, p. 6).

Cultural Pluralism--A concept which recognizes the unique contributions of multiethnic groups to the larger society. It encourages harmony, respect, and cooperation within a culturally diverse society.

Discrimination--Behavior, directed at an individual or group, that is differential and pejorative.

Ethnicity--The social or cultural heritage a group shares that relate to customs, language, religion, traditions, distinctive dress, foods, mode of life passed on from one generation to the next.

Ethnocentrism--The belief that one's group (family, country, culture, belief system) is right and must be defended. "Rightness" or "wrongness" is not at issue. (This is a basic human survival response.)

Eurocentric Orientation--The belief in the comparative superiority of Anglo/American culture in particular, and in Euro/American culture in general. It emphasizes Western European values, ethos, and beliefs, valuing mastery over nature, competition, individuation; and theoretically, at least, it emphasizes rigid adherence to time.

Melting Pot Myth--A concept that implies that members of the "American" Society have conformed to a certain set of standards and characteristics, usually "White-Anglo-Saxon-Protestant" norms. (The notion that people from diverse cultures lose their ethnicity for the sake of the larger society is a myth, for ethnicity, ethnic neighborhoods, and interest in ethnic identity continue to be a part of the fabric of American Society.)

Multicultural Counseling--Defined by Lee as "an intervention process that places equal emphasis on the racial and ethnic impressions of both counselor and client" (1991, p. 229).

Multiculturalism--The process in which individuals develop skills to interact in an intercultural framework, where diverse cultures are represented, and differences are bridged.

Prejudice--An attitude that predisposes knowledge, beliefs, and behaviors regarding diverse groups.

Race (Racial)--Biological differences of physical characteristics or genetic origin that might differentiate one group of people from another but does not justify or explain differences in social behavior where similar patterns cut randomly across racial lines. (Increasingly, physical anthropologists and biologists are reassessing the concept of race and finding it to be of no scientific use whatever.)

Racism--The cumulative effects of prejudice and discrimination which result in the oppression of a group.

Appendix B

Case Studies in Cultural Diversity

The Case of John

Case Description

John, a single 29 year old Pacific Islander, was thrown from the back of a pick-up truck and sustained a head injury which resulted in a disability (right hemiplegia). John was flown to Honolulu from his home island for emergency medical services at a medical rehabilitation hospital not available on his home island. John was ambulatory at the time of discharge from the rehabilitation hospital and was referred for vocational rehabilitation. Medical records did not indicate cognitive impairment.

The initial assessment revealed that prior to John's head injury, his size (six foot three inches and 220 pounds) and strength were assets. He had a reputation as a good worker when employed as a laborer and contributed much of his time to working on the family farm.

On John's home island, farming involves working on small plots of land by hand, often in rugged terrain. The growing of subsistence crops and traditional foods continues to be an important role for young men in John's Pacific Island community. English is a second language for John. He has completed high school; however, he has expressed little interest in higher education.

At this time, one month after discharge and seven months after arriving in Honolulu, John is living alone, continues receiving outpatient therapy and has become involved in a therapeutic exercise program. He has minimal contact with extended family members who live in Honolulu, and little or no contact with Pacific Island oriented church and community groups.

Relevant Issues

Medical rehabilitation services are very limited on John's home island. Priority for therapy is given to inpatients. Related services (e.g., therapeutic exercise) are not available. John's island does have a vocational rehabilitation program.

Persons with John's cultural background value interdependency among family members, as members of an extended family are expected to share or pool resources in order to meet the needs of the family and its members. Older family members, in particular the head of the extended family, would be involved in decisions regarding the use of family resources. The head of the family may also be expected to be involved in decisions regarding the employment of individual members.

Involvement in extended family, community, and church activities would be expected, given John's cultural background. However, he is living alone and has not indicated any participation in an extended family or ties to community and church groups in Honolulu.

Analysis Questions

John's behavior (e.g., living alone and disconnected from family, community, and church groups) is inconsistent with what might be expected of an islander. Questions such as the following might be of use in directing the rehabilitation counseling process.

- What is the history of John's involvement with family, community, and church and has that involvement changed?
- If there are changes, are they associated with his disability, his status in the family and home community, his moving to Hawaii, or a combination of factors?
- Has John experienced cognitive and/or psychological impairments that have not yet been identified?
- Have John's physical limitations changed his self perception as a "good worker" and "contributor" to the family?
- How will John's physical limitations impact on his role in the family and the recognition he has received as a good worker and family provider?
- Does John expect to return home or remain in Honolulu?
- How will remaining in Honolulu impact on John's vocational rehabilitation?
- How will returning home impact on John's vocational rehabilitation?
- In addition to John, who should be involved in the rehabilitation planning process?

Potential Barriers

Counselors who do not have knowledge of the language and culture of an individual from a minority group or have access to persons with such knowledge (e.g., family member, co-worker, culture broker, etc.) are not able to adequately assess client needs and plan appropriate services.

Even with some knowledge of the client's culture, counselors who have an ethnocentric view of the rehabilitation process will provide inadequate services. For example, a counselor who places greater value on individualism and independence may not understand the worldview of a person who places greater value on interdependence and familial relationships.

Also, a counselor's knowledge of a particular culture can be inappropriately used. For example, the counselor may under-emphasize the possibility of individual differences among clients from a particular minority group.

Lack of knowledge regarding community resources, both formal and informal (e.g., support from members of an extended family), serves as a barrier to effective service planning and delivery. Communities with inadequate formal resources (medical rehabilitation and related therapeutic services) may have strong informal support systems. Frequently, these informal support systems are underutilized.

The Case of Mr. Sanchez

Case Description

Mr. Sanchez is a forty-five year old male of Hispanic descent. He completed the sixth grade in Mexico and has worked mainly in the United States since the age of 16 as a laborer in the onion fields. Mr. Sanchez sustained a back injury and is now limited in lifting and carrying. Six months ago Mr. Sanchez's physician released him to return to work but is recommending a sedentary employment position. Mr. Sanchez's vocational evaluation report indicated the following:

- Reading level is below the third grade.
- Vocational interests are further farming tasks, gunsmith, and/or locksmith vocations.
- Finger and manual dexterity are above average.
- Ability to follow complex instructions was below average.
- Evaluator stated, "questionable motivation to return to work as the client did not seem to be interested during the evaluation, i.e., late to testing, lackadaisical about assigned testing".

Analysis Questions

Additional questions that must be answered as the background above is very brief are:

1. What is the preferred language of this client?
2. Is it easier for the client to read English or Spanish?
3. Did the vocational evaluator make instructions and written tests available in the client's preferred language?
4. How healthy is the family's financial situation, i.e., is the wife working for the first time?
5. How many people does the client financially support, i.e., family in Mexico?
6. How equivalent is a sixth grade education from Mexico as compared to an American sixth grade education?
7. Does the client understand the need to refrain from lifting occupations, or does he only value a "real day's work" as physical labor?

Potential Barriers

Based on the information provided in the case scenario the counselor might rule out any technical training due to a low reading level and "lack of motivation." Often, a person who has suffered a break in work history and contribution to their family income may be experiencing low self-esteem or fear. The counselor would want to know how the client felt about the evaluation process and taking "tests" in general. Was testing information available in Spanish if Mr. Sanchez had wanted it?

Did he feel the testing results truly represent his abilities? How does he feel about seeking help from government services. Is he planning to find work through his own network in the neighborhood no matter what VR attempts?

Local Resources

The counselor could seek a professional colleague who is bilingual or works in the Hispanic community to discuss possible cultural barriers in this case. Usually, VR has such a professional on staff. This professional often is highly invested in the removal of cultural barriers in client relationship and, therefore, enjoys helping other counselors. Sometimes counselors feel that asking other professionals for ideas shows weaknesses. In fact, much can be learned. In every instance, however, confidentiality must be maintained.

Another resource to develop is the client's spouse and extended family. After discussing the level of involvement the client will permit with the extended family, the counselor working with persons of Hispanic descent will often find the spouse and others to be valuable allies in the client's rehabilitation.

The Case of Jim

Case Description

Jim Blackeagle, a 27 year old Creek Indian male sustained an internal head injury in a motorcycle accident on May 17, 1989. A 1983 graduate of a Georgia high school, Jim continued his vocational preparation at a Georgia Vocational Technical College. He graduated in June 1985 with an Associate of Arts degree (AA) in computer technology. During high school and Technical College he worked part-time (20-30 hours per week) for a sporting equipment manufacturer. Upon obtaining his AA degree, he was employed full-time as an Inventory Control Specialist with a sporting equipment company.

Before the accident, Jim had his own apartment, the first time ever away from his single-parent home. He is the second oldest in a four-child family with an older brother, two younger sisters, and his mother. His father left the home when Jim was five years old (1970).

Following stabilization at an Atlanta medical center, Jim was transferred to the Roosevelt Warm Springs (Georgia) Rehabilitation Institute. Total family support services were provided, and "cautiously received," as Jim's mother was skeptical of the vocational rehabilitation system, overall. To further compound the family distrust issue, the VR counselor had documented difficulties in relating to Native Americans. The counselor was seen as an arrogant and insensitive paper-pusher by Jim and his family.

Jim's employer provided leave without pay after his sick and annual accumulations were depleted. Following four months at the rehabilitation center, he was released and returned to live with his family. The VR counselor-family relationship aside, a vocational evaluation/training (OJT) process determined that--with assistance--he could resume "some aspects of his previous position." For seven weeks, VR paid half of his salary (on OJT). For three months, VR funded a job coach under supported employment for Jim. While he was involved with relearning some dimensions of his position, Jim and his family became active in the local group of the Head Injury Support Family, an organization which assumed the job coach function when VR withdrew support.

Some of the results of the closed head injury which Jim sustained include:

- Denial of permanence of injury
- Undue optimism (i.e., hope for 100% cure)
- Impairment in expressive dimension of communication/memory
- Frustration and confusion
- Time, relationship, and trust issues compounded

His pre-injury personality (friendly, out-going, self-starter, determined) coupled with his strong family support and encouragement, served to mitigate the effects of his TBI.

Relevant Issues

Some of the culturally relevant issues which surfaced in this case include:

- Non-trust of a governmental system
- Non-understanding by client and his family of how to access the VR system
- View by the client and his family that the TBI was a form of "punishment"
- Ineffective relationship between VR counselor, client and family

Potential Barriers

The potential barriers to the effective follow-up of this particular case include those obstacles found in ***any*** consumer-counselor-employer-family situation. Additionally, the complications of cultural diversity in all dimensions of this phase of the VR process (i.e., counselor arrogance, client/family distrust, middle-class values of employer, etc.) further obstruct the client's movement through the VR process.

Analysis Questions

1. Given the distrust common among Native American Indians toward any governmental system, why assign a VR counselor who has documented difficulties in effectively relating to Native-American clients?

2. What strategies could be employed that might assist the client and family to effectively deal with, and resolve, the frustration and confusion associated with this follow-up period?

3. What other community home-based services could be offered which might expedite Jim's return to his pre-injury level of independence?

4. What VR actions or interventions are appropriate to acknowledge/resolve the VR counselor limitations inherent in this specific case and, to a much larger extent, to cultural difference?

5. What culturally-appropriate suggestions or assistance could the VR agency provide to the employer during this follow-up phase of rehabilitation/return-to-work?

6. From the perspective of the Creek Indian culture, what questions, concerns, and issues are most important at this point (follow-up) of the rehabilitation process?

7. From Jim's point of view, what can be done to facilitate his success during this follow-up phase? What can be done to ensure lasting effects of the progress he is experiencing?

The Case of Maria

Case Description

Maria Elena is a 28 year old South American, single female. She worked as a field hand from the age of 12 through 17, but had trouble doing this work because it required prolonged standing and walking (one leg is 3 inches shorter than the other). After leaving her job as a field hand, she moved to Matamoros, Mexico, where she lived with a cousin and his family. She worked at a Matricadora (an American owned company in Mexico employing local residents at reduced wages to export finished products to the US) as a seamstress on an assembly line. Maria Elena was fired from this job because she could not follow single instructions in the employees' guide book (written in Spanish).

A year ago Maria Elena moved to Brownsville, Texas, in the Rio Grande Valley and worked as a part-time maid averaging 2-3 days a week. Having completed the paperwork necessary to work legally in the US she has moved to Houston and has requested vocational rehabilitation services.

Analysis Questions

- What are cultural characteristics of this person?
- Is this client willing to partake in traditional diagnostic evaluations?
- If the client were to go through traditional diagnostic evaluations, would the results be valid and reliable in your community?
- Are there internal and external support systems?
- Are there appropriate accommodations available to determine clients needs and potential?
- Would the client be more comfortable with a translator or a Spanish speaking evaluator/doctor?

The Case of Shu-Li

Case Description

Shu-Li is a 19 year old Vietnamese female who became deaf at age five as a result of a childhood illness. Shu-Li, her mother, uncle, and two younger siblings fled Vietnam as a part of the second wave of refugees in 1982. Her father and one brother were left behind in Vietnam. Her mother has acquired limited English language skills and has found part-time work in a local Vietnamese American restaurant. Her uncle is unemployed. A local Methodist church "adopted" Shu-Li and her family and made the referral to the VR agency. The family receives some support through the state public assistance agency. There appears to be a number of Vietnamese families in the community. Shu-Li's basic language development is in Vietnamese, and she has acquired a few American Sign Language (ASL) "survival" communication skills. She had participated in special education classes for two years before she dropped out. She spent a month at a rehabilitation workshop in work evaluation and work adjustment training. The available information from the workshops indicated that "she seems to catch on quickly, has good eye-hand coordination, very pleasant--smiles a lot--but is not sociable. The special education reports seem to contradict this information indicating that Shu-Li is withdrawn and unable to handle simple tasks. While in school, Shu-Li was occasionally made fun of by her classmates due to her deafness and her national origin.

The counselor has little other assessment data available. Shu-Li feels pressured to obtain work to assist the family. Available medical information shows no other discernible physical limitations although she has begun to describe recent severe headaches. Her uncle has expressed disappointment that Shu-Li did not finish school and that she has made no real contribution to the family. Shu-Li (through an interpreter) has been agreeable to all of the suggestions made by the counselor but has offered little information about herself or her interests.

Relevant Issues

- Asian-American culture believes in solving problems within the family setting first
- Important to avoid shame to family
- Traditionally not assertive, especially with authority figures
- Important to focus on client-perceived issues first (i.e., housing, jobs)
- Link to families is important
- Action orientation with clear expectations and objectives is more desirable approach
- Communication style: avoids eye contact, physical distance in speaking, low keyed, and indirect
- Mental or emotional issues may be masked or defined as physical problems

Potential Barriers

- Traditional counseling may not be highly valued; logical, rational approach may be more favorably received than a non-directive reflective method
- Asian-Americans may not be comfortable in self-disclosure in a counseling setting

- Vietnamese differ from other Asian-Americans in that the majority are foreign-born and come to the US as refugees (necessary vs. elective immigration from their homeland).
- The refugee status has social/emotional implications, e.g., trauma as a result of leaving their home country and the problems associated with resettlement and adjustment in the US.

Cultural Values and Demographic Information

- Value of interdependence
- Harmony with nature
- Strong link between mental state and physical state
- Deference to authority
- High regard for education
- High respect for parents
- Group is more important than individual
- Time orientation emphasizes the past and present as opposed to future
- Asian-Americans are fastest growing minority population
- "Asian-American" references some 29 different subgroups including Chinese, Japanese, Filipinos, Koreans, Vietnamese, and Asian Indians as the major groups in this country.

Discussion Questions

1. What are the salient cultural values, strengths, and beliefs to consider in the rehabilitation plan? How might they affect the plan implementation and eventual outcome?

2. What issues are imposed by language and communication and how might they be addressed?

3. What is the cultural and individual orientation toward work? Does it present a barrier or opportunity?

4. What do you anticipate the level of acculturation and assimilation into dominant American culture to be? How will this be addressed in planning?

5. What is the cultural view towards counseling and how will the counselor establish trust and credibility?

6. What is the role of the family and how should a family member(s) be involved in the rehabilitation process?

7. Which key community services and resource persons are available and how might they be used?

8. What other important issues exist and how should they be addressed?

Appendix C

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